

Reproductive & Child Health Programme

# Module For Health Assistant (Male)

*Integrated Skill  
Development Training*



राष्ट्रीय स्वास्थ्य एवं परिवार कल्याण संस्थान  
National Institute of Health and Family Welfare

मुनीरका, नई दिल्ली-110 067  
Munirka, New Delhi-110 067



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# MODULE FOR HEALTH ASSISTANT (MALE)

RCH PROGRAMME



आरोग्यम् सुखसम्पदा

राष्ट्रीय स्वास्थ्य एवं परिवार कल्याण संस्थान  
**National Institute of Health & Family Welfare**

मुनीरका, नई दिल्ली- 110 067

Munirka, New Delhi- 110 067



MODULE FOR

HEALTH

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June 2001

ASSISTANT

(MALE)

RCH PROGRAMME



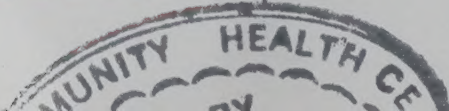
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## Preface

The need for and underlying principles of Reproductive health as an approach to solve the population issues were duly highlighted and agreed upon by participating countries during the International Conference on Population and Development held in Cairo in 1994. In agreement to this decision, the Government of India has formally launched the Reproductive and Child Health (RCH) programme on October 15, 1997. This programme has envisaged a major shift in certain components, approach and emphasis of the already existing Family Welfare Programme in the country. Major focus in this programme is delivery of need based, client centred, good quality, comprehensive reproductive and child health services to all the beneficiaries in an integrated manner. In India the RCH services are to be delivered through the existing primary health care infrastructure with necessary referral and supervisory support from the secondary and tertiary level institutions.

Capacity building among the personnel involved in the RCH services delivery through in-service training is considered as an essential prerequisite for the successful implementation of the programme. While various skills are to be acquired by the health personnel, major attention is being focussed on clinical skills along with communication and managerial skills. Accordingly, Integrated Skill Development training of primary health care personnel is being organized in which they are trained in these components in an integrated manner throughout the country.

The National Institute of Health and Family Welfare, which is the nodal agency for coordinating various training activities under RCH programme in the country, has developed this training module for enabling the Health Assistant (M) to acquire competency in the different service components as well as to supervise the functioning of the Health Worker (M). It is expected to be a training resource material as well as a ready reference for these functionaries.

The contents of the module are presented in 5 Blocks. The first Block, on management, deals with the basic principles of management and highlights the specific managerial responsibilities of the Health Assistant (M); like supervision of Health Workers in decentralized planning using Community Needs Assessment Approach, essentials of logistics and supplies management, supervision of management information system etc.

The Block on Communication covers the essentials of communication process, supervision of communication activities, Interpersonal communication and counselling as a major input in enabling behaviour change among people and social mobilization.



Block on Maternal Health deals with safe abortion, contraception, prevention and management of Reproductive Tract Infections (RTI), Sexually Transmitted Infections (STI) etc.

The Block on Child health covers important interventions included under child health care; like immunization, ARI control, Diarrhoeal Diseases control, nutrition etc.

Realising the importance of adolescents' reproductive health, a separate, though brief block has been included on this subject, which primarily sensitizes the Health Assistant (M) to its importance and need for IEC in informing adequately and counselling the adolescents regarding their own health needs and precautions to be taken to safeguard their health.

This module is an outcome of efforts by NIHFW which passed through various stages of reviews and refinements with the support of a number of experts from different professional settings. Their contributions are thankfully and profusely acknowledged. Efforts have been made to make this module as comprehensive and self-sufficient as possible for meeting the RCH training needs of the Health Assistant (M) particularly based on the training guidelines evolved by GOI in 1996. Errors and omissions, if any, may be brought to the notice of NIHFW for corrections and modifications in the future editions.

New Delhi

**Dr. M.C. Kapilashrami**  
**Director**  
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## Acknowledgement

The National Institute of Health and Family Welfare gratefully acknowledges the effort and cooperation it has received from institutions and experts from different parts of the country in preparing the module for the Health Assistant (M). The module was written by the in-house faculty of NIHFV and the Training and Administrative staff of the RCH Project of NIHFV. The module was subsequently reviewed by a panel of experts and professionals from the respective fields during different stages of its preparation. These experts were drawn broadly from four areas viz. Management, Communication, Maternal Health and Child Health. The module presented here has been developed, based on their valuable advice, comments and suggestions.

It is one of those rare occasions that experts from different specialist areas like Communication and Management worked in close collaboration with maternal and child health experts to look at the reproductive and child health issues in the context of the actual work situation of a Health Assistant (M). Special thanks are also due to the following experts from different agencies and organizations who gave their valuable suggestions.

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## List of Abbreviations

<b>A</b>	AIDS	Acquired Immuno-Deficiency Syndrome
	ANC	Antenatal Care
	ANM	Auxiliary Nurse Midwife
	ARI	Acute Respiratory Infection
	AWW	Anganwadi Workers
<b>B</b>	BBT	Basal Body Temperature
	BCG	Bacillus Calmetti Guerin
	BP	Blood Pressure
<b>C</b>	CHC	Community Health Centre
	CNA	Community Need Assessment
	CuT	Copper T
<b>D</b>	DDC	Drug Distribution Centre
	DDK	Disposable Dai Kit
	DPT	Diphtheria, Pertussis, Tetanus
	DWACRA	Development of Women and Children in Rural Areas
<b>E</b>	EDD	Expected Date of Delivery
<b>F</b>	FA	Folic Acid
	FRU	First Referral Unit
	FTD	Fever Treatment Depot
<b>H</b>	H.Mole	Hydatidiform Mole
	H/O	History of
	HAF	Home Available Fluid
	Hb	Haemoglobin
	Hg	Mercury
	HIV	Human Immunodeficiency Virus
	HLD	High Level Disinfectant
	HPV	Human Papilloma Virus
	HW (M)	Health Worker Male



<b>I</b>	I/M	Intramuscular
	I/V	Intravenous
	ID	Intra Dermal
	IFA	Iron Folic Acid
	ILR	Ice Lined Refrigerator
	IP	Infection Prevention
	IPC	Interpersonal Communication
	ISS	Isthree Swasthya Sangh
	IUD	Intrauterine Device
	IUGR	Intrauterine Growth Retardation

<b>L</b>	LA	Lactational Amenorrhoea
	LMP	Last Menstrual Period
	LSCS	Lower Segment Caesarean Section

<b>M</b>	MCH	Maternal & Child Health
	MLV	Malaria Link Volunteer
	MO	Medical Officer
	MR Syringe	Menstrual Regulation Syringe
	MSS	Mahila Swasthya Sangh
	MTP	Medical Termination of Pregnancy

<b>N</b>	NGOs	Non-Governmental Organizations
	NMEP	National Malaria Eradication Programme
	NNT	Neonatal Tetanus
	NSV	Non-Scalpel Vasectomy

<b>O</b>	OCP	Oral Contraceptive Pills
	OPV	Oral Polio Vaccine
	ORS	Oral Rehydration Salt

<b>P</b>	P/A	Per Abdomen
	P/V	Per Vaginum
	PHC	Primary Health Centre
	PIH	Pregnancy Induced Hypertension
	PLA	Participatory Learning for Action
	PPH	Post Partum Haemorrhage
	PROM	Premature Rupture of Membranes



<b>R</b>	RCH	Reproductive and Child Health
	RMP	Registered Medical Practitioner
	RTI	Reproductive Tract Infections
<b>S</b>	SC	Sub Cutaneous
	SD	Single Dose
	STD	Sexually Transmitted Diseases
	STI	Sexually Transmitted Infections
<b>T</b>	TT	Tetanus Toxoid
	TBA	Traditional Birth Attendant
<b>U</b>	USG	Ultra Sonography
	UTI	Urinary Tract Infection
<b>V</b>	VDRL	Venereal Disease Research Laboratory
	VVM	Vaccine Vial Monitor









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## Introduction

The rapidly growing population had been a major concern for health planners and administrators in India since independence. The result was the launching of the National Family Planning Programme by the Government of India. India is the first country to have taken up the family planning programme at the national level.

Poor health status of women and children in terms of high mortality and morbidity was also another health priority in this country. Health facilities like hospitals and health centres were established for providing Maternal and Child Health (MCH) care through ante-natal, intra-natal and post-natal services. In addition, a number of special programmes and schemes like immunization against vaccine preventable diseases, nutritional interventions like iron and folic acid distribution and vitamin A supplementation, diarrhoeal disease control through Oral Rehydration Therapy (ORT), Acute Respiratory Infection (ARI) control programme etc. were implemented in the past. In order to ensure maximum benefit from these programmes and to provide services in an integrated manner to this vulnerable group, the Child Survival and Safe Motherhood (CSSM) programme was implemented in India since 1992.

Despite all these efforts, the desired impact on the population growth and health/development of women and children in the country could not be achieved and the need for a new approach to the problem was felt. In 1994, during the International Conference on Population and Development (ICPD), held in Cairo it was recommended that a new approach needs to be adopted to tackle the problem. Under this approach it was decided that family planning services should be provided as a component of the comprehensive reproductive health care. Reproductive health approach implies that men and women be well informed about and have access to safe and effective contraceptive methods as well as women can go through pregnancy and child birth safely and that couples are provided with best chance of having a healthy infant.

Being one of the 180 countries, which participated in the ICPD conference, India also agreed to the decision taken during the conference to adopt the reproductive health approach to the population issues. Accordingly, as a follow-up action to this conference, the Government of India launched the Reproductive and Child Health (RCH) programme in October, 1997.

With the new approach under the programme, it is expected that health personnel including you will be enabled to understand more easily and completely the service needs of the population and deliver services accordingly. The RCH

programme is envisaged to provide an integrated package of services, which will include the following:

- Services for mothers during pregnancy, child birth and post-natal period including safe abortion services when required,
- Services for children including newborn care, immunization, Vitamin A prophylaxis, Oral Rehydration Therapy (ORT) for diarrhoea, management of Acute Respiratory Infections (ARI), anaemia control etc.,
- Services for eligible couples through promotion of use of contraceptive methods as well as infertility services when required,
- Prevention and management of Reproductive Tract Infections (RTIs), and
- For adolescents, health services including counselling on family life and reproductive health.

For rendering the above services the new approach under the RCH programme places special emphasis on **client-oriented, need-based, high quality, integrated services** to the beneficiaries. There has been a major shift/change in the approach from the past and some important ones among these are:

### 1. Target Free Programme Based on Community Needs

In the past the workload was estimated by the health functionaries based on the centrally determined contraceptive method-specific targets. Under the RCH programme, this method is withdrawn and in its place you yourself can estimate your workload by using **Community Need Assessment Based Approach (CNAAB)**. Since 1996, the Government of India has started the implementation of this approach.

### 2. Participatory Planning

The estimation of services required and its planning are to be actually undertaken by you with active involvement and consultation with community members including women's groups, panchayat institutions/members, etc.

### 3. Greater Emphasis on Quality of Care and Client Satisfaction

Under the RCH programme, special emphasis is placed on good quality of care. Therefore, you have to ensure that all services provided by you are of good quality and acceptable to the clients. This can be achieved by ensuring adoption/practice of technically correct procedures by health personnel including you while rendering various services. It also requires better interpersonal relationship between clients and service providers informing them about causes and seriousness of their health problems and types of services currently available and their sources. You have to also provide counselling services wherever needed so that the clients are enabled to take correct decision for accepting services.



This, in turn, is expected to increase satisfaction with the services received among clients and thereby further increase the acceptance of services.

Well trained and highly motivated health personnel are essential pre-requisite for successful implementation of this programme which deals with highly sensitive and personal aspects of life like contraception, abortions, maternal and child health services etc. In order to provide RCH services under the changed approach described above, service providers including you should have a desirable degree of technical competence and in addition skills in effective communication as well as managerial capabilities. Therefore in-service training of all personnel is an essential intervention for success of this new approach to the programme by sensitizing them to the new approach as well as developing skills through hands-on-training.

You would appreciate that in providing the RCH services to the appropriate needy clients as an integral component of primary health care, you have a major role to play. In order to enable you to perform your role most effectively, you need to be exposed to the refresher/in-service training in a systematic manner. Under the RCH programme, this is being undertaken through RCH Awareness Generation Training (AGT) programme as well as through Integrated Skill Development Training programme being conducted by identified training institutions.

Through the Awareness Generation Training, at the grassroot level all field functionaries not only from the Department of Health and Family Welfare, but also from various other development sectors like education, rural development, women and child development as well as community leaders, members of Mahila Swasthya Sangh and Panchayat members are sensitized to the various aspects of RCH programme.

The Integrated Skill Development Training of varying duration is provided for all categories of health personnel including doctors, nurses and paramedical workers at the Primary Health Centres. For you, this training will be of 6 days duration. During this training, you will be given in-depth orientation about conceptual/theoretical details about the RCH programme. This training will also include practical hands-on-training on all important components of RCH programme so as to improve your clinical, communication and managerial skills. In order to enable you to effectively supervise the various activities performed by the HW(M) specific theoretical and practical guidelines on supervision are also included.

This module is developed to help you in improving your knowledge and capability for providing better quality of RCH services to the community as well as to effectively supervise and facilitate functioning of the HW(M). You can use this as a resource material, to read and understand during the training, and as a

reference material even after the training course is completed. This contains the following five blocks viz.

1. Management,
2. Communication,
3. Maternal Health ,
4. Child Health, and
5. Adolescent Health.

Each block has been divided into units and sub-units which contain theoretical concepts along with practical exercises/illustrations/case materials at appropriate places as well as self-assessment questions to make your learning, interesting and effective.





# Management

for

## *Health Assistant (Male)*







## ***Introduction***

The Reproductive and Child Health (RCH) Programme was launched throughout the country on 15<sup>th</sup> October 1997. This Programme aims at achieving a status in which people will be able to regulate their fertility, women will be able to go through their pregnancy and child birth safely, the outcome of pregnancies will lead to well being and survival of the mother as well as of the child and couples will be able to have sexual relation free of fear of pregnancy and of contracting sexually transmitted diseases.

The RCH concept consists of providing to the beneficiaries need-based, client-centred, demand-driven and high quality integrated services which include:

- Maternal health services
- Child health services
- Prevention of unwanted pregnancies
- Prevention and management of RTI/STI
- Adolescent health services

The provision of good quality care is the crux of the RCH Programme. Thus, greater emphasis is given to quality of services under the RCH Programme than what had been the case under National Family Welfare Programme. Good quality of services is determined by:

- Type of services provided – need-based, informed choice and adequate
- Follow-up,
- Competence of the service provider i.e., the Health Worker at sub-centre level,
- Good quality equipment which is correct, appropriate, well-maintained and well-utilized,
- Social aspects
  - Gender sensitivity
  - Timing for provision of services suitable to women
  - Encouraging male participation
  - Involvement of women in the programme.

In order to ensure provision of quality services, the RCH Programme strategy includes:

- Community Need Assessment and sub-centre planning for ensuring need-based, client-specific and demand-driven services.
- Adequate management of these RCH services at each level in terms of the factors responsible for quality of services,
- Training has been included under the RCH Programme for improving task performance and competence of the service providers.

The training for the Multipurpose Health Workers, Health Assistants and Medical Officers at PHC has been designed as an Integrated Skill Training course which not only aims at improving technical competence for performing a task but also improving the managerial capability in terms of need assessment, involvement of other village level workers, estimation of material requirement, maintenance and utilization of equipment, maintenance of records and reports for making these services effective. The module in question has been prepared for the management component under the Integrated Skill Training of Male Health Supervisors.

The Management Training Module for Male Health Supervisors under the Reproductive and Child Health (RCH) Programme will help you perform managerial responsibilities for the services to be provided at the sub-centre level, more effectively. The module has been divided into five major units that deal with the important management aspects of the services to be provided at the sub-centre level. In each unit, the learning objectives as well as the major content areas are highlighted before examining each aspect in detail. At the end of each unit, Key points are given to reinforce the important aspects. The objective is to make it easy for the Health Assistants to remember these key issues as they go about with their work.

The units incorporated in this module are listed below:

Unit – I A	Community Need Assessment and Sub-Centre Planning
Unit – I B	Preparation of Sub-Centre Action Plan
Unit - II	Management of Drugs, Vaccines and Other Supplies
Unit – III	Team Work and Leadership
Unit – IV	Supervision and On-the-Job Training
Unit – V	Maintenance of Records and Reports



## ***COMMUNITY NEED ASSESSMENT (CNA) AND SUB-CENTRE PLANNING***

### **LEARNING OBJECTIVES:**

With the help of this unit, you should be able to:

- ❑ Explain the concept and purpose of CNA approach.
- ❑ Explain the community need assessment process.
- ❑ Demonstrate how to carry out the consultative process for CNA in the community.
- ❑ Explain what is sub-centre planning for health and family welfare services.

### **CONTENTS:**

- ❑ Concept and Purpose of CNA [What is CNA and Why it is needed]
- ❑ Consultative process for CNA in the community. [How CNA can be conducted]
- ❑ Sub-Centre Planning

### **1.1 INTRODUCTION:**

Under the National Family Welfare Programme, targets for each service were fixed at higher level and passed on to the health functionaries at different levels. There were also cash incentives for

the health functionaries as well as the client for each case. This resulted in inflation and manipulation of performance, which deteriorated the quality of services. In order to overcome this, the Government of India and all the State Governments together decided to stop fixing targets at higher level and passing these to lower level. Instead, the health workers including Health Assistant (Male) would assess the community felt needs and estimate workload at their own level through consultation with the community people. With this approach, it is expected that client-centred and demand-based services can be provided at sub-centre level.

This new approach was initially referred to as '**Target Free Approach**', but this was not understood correctly by most of the health functionaries. Therefore, it was later renamed as 'Community Need Assessment' approach. Since, this process is to be initiated at the sub-centre level, the entire work plan for providing relevant services adequately depends on the effectiveness of the CNA process. It is for this reason that the Health Assistants (Male) along with the male health workers must understand it very clearly so that they are able to assess the community needs and then estimate service requirement for the people in his area and is able to provide these services effectively. This unit will help you in this direction.

## **1.2 CONCEPT AND PURPOSE OF CNA:**

### **1.2.1 What CNA means?**

The overall objective of the Family Welfare Programme has been to stabilise the population of the country. It has been realised that this can be achieved by providing quality health and family welfare services and promoting use of birth spacing methods based on actual needs of the people and not on the needs as perceived by the top level health personnel. Thus, the approach has been changed to planning for each health care services as per actual needs estimated by the service providers at their own level instead of pursuing the set targets passed on to them. This approach for need assessment and planning for services to be provided is referred to as "**Community Need Assessment**" (CNA) approach.



### **1.2.2 Purpose of CNA:**

Through CNA approach services will be provided to the people in the community based on their actual needs as these will be assessed systematically and therefore these would be relevant to local situations. Thus, it would help in:

- Setting priorities.
- Identifying target as well as high-risk groups.
- Realistic estimation of services and matching of resource needed for the same.
- Developing a realistic action plan/work plan for you.

### **1.3 CNA PROCESS:**

In this approach, the process suggested for assessment of community needs is by conducting household survey and consultation with representatives of the community and other functionaries working in the same community. Hence, the CNA approach is:

- Based on felt needs of the community.
- Not to give uniform target to all sub-centre's as was done in earlier approach but to develop realistic work load based on actual needs of the people for different services.
- Also based on actual capacity of the service provider.
- Based on people's involvement and consultations with them for larger coordination, cooperation and for better utilisation of the services.

#### **1.3.1 Steps For CNA Process:**

At village level, the Female Health Workers should develop a team with the support and help from the Male Health Worker consisting of the following members:

- Anganwadi Workers (AWWs)
- Traditional Birth Attendants/Dais (TBAs/Dais)
- Mahila Swasthya Sangh or equivalent women's group members i.e., (DWACRA etc.)
- Village link persons (if any)
- Leaders of youth organisations

These members can directly collaborate with the Male Health Workers under your supervision in conducting the household survey, collection of other relevant information and reporting of the major events like - birth, death, marriage, epidemic etc. You must ensure that both the male and female health workers share the responsibilities and divide the sub-centre area for the survey amongst them. The other members who could be included in the group during CNA for consultative process are:

- Sarpanch, Pradhans, Village Panchayat members etc.
- School teachers.
- Religious leaders/priests.
- Members of NGOs.
- Members of informal organisations in the villages.
- Medical Practitioners of any system of medicine.

The group members mentioned above, would be an asset to you in providing more information along with the household survey and also in validating of certain information being provided and collected by the team.

As one of the supervisors you should ensure that the male health workers get involved and help the female worker to organise meetings regularly with the consultative members and other team members and involve them in planning and providing services. For organising meeting with the consultative group, you must take help from the Sarpanch for conducting the meeting. This will ensure attendance of all these members. These members can help you in correct assessment of the community needs and follow-up of various services provided by you. They should give them feed back



regarding the actions they have taken or services that the sub-centres in the area have provided and how much of these services have been utilised by the community members. You have to ensure that the information that the Health Workers share with them must include:

- i) The children who were brought for immunization,
- ii) The children who were not brought for repeat doses,
- iii) Number of RTI/STI cases registered,
- iv) Number of male sterilisations done,
- v) Number of eligible couples using condoms,
- vi) Number of cases under 5 with acute diarrhoea registered regularly,
- vii) Number of RTI/STI cases advised to go to FRU/hospital for checkup,
- viii) Number of children under 5 with pneumonia who actually went to PHC/FRU.

The members of consultative group can undertake follow up of the cases and give feed back in the next consultative meeting.

### **Steps for CNA and Consultative Process**

You have to ensure that the Health Workers

- ◆ Develop a working team consisting of village health functionaries, link persons and leaders of youth organisations at every village.
- ◆ Form a consultative group of Panchayat members, teachers, priests, opinion leaders etc.
- ◆ Conduct household survey with the help of the working team.
- ◆ Consult the consultative members for collection of more Information and confirmation or validation of the information collected through survey.
- ◆ Estimate the needs for each health and family welfare services based on the analysis of survey data
- ◆ Hold meetings of the working team & consultative members every month regularly.
- ◆ Share information regarding services provided and seek feedback.

## 1.4 SUB-CENTRE PLANNING:

In earlier approach, as the targets were fixed for the health workers and a fixed amount of material/equipment was supplied to each sub-centre, there was no need for you to work out any plan for the service needs to be provided. But in the present set up, you have to assess the needs of the people in the community and estimate service requirement for meeting these needs. Hence, you should plan for providing these services and estimate the material/equipment required. Based on this estimation of services and resource (material/equipment) requirement, supply will be made from PHC level to facilitate you to provide these services. This is referred to as Sub-Centre Planning.

The health workers are expected to prepare Annual Action Plan and submit it to MO (PHC) by 10<sup>th</sup> March every year. You as the supervisor will have to guide and support them in preparation of this annual action plan. Hence, you should know how it is done and able to guide them. The details of how to prepare this Sub-Centre action plan on the given format from GOI is given in Unit 1 B.

Planning at sub-centre level is crucial as all the sub-centre plans are compiled at PHC level for preparation of action plan for each PHC.

All the PHC Medical Officers submit these PHC plans to the District, which along with other services provided at district level form the Annual District Plan. All the district plans are put together to prepare annual plan for the State.

Thus, the planning for all the service components of RCH programme starts from the most peripheral level and goes up to higher level. You may be expected to assist the MO (PHC) in compiling all the sub-centre action plans received at PHC and then prepare the PHC action Plan. Hence, it is critically important for you to follow the steps and make sure that these are carried out properly.



Hence, planning done at sub-centre level is not only need-based but also scientific and realistic.

Effective planning at sub-centre level is crucial as all the sub-centre plans are compiled at PHC level and the components of other services to be provided only at PHC level such as MTP, number of RTI/STI cases to be treated and referred are added to prepare action plan for each PHC.

Thus, all the PHC plans and plans for other components at district level form the basis of annual plan for the district.

### **KEY POINTS**

- ◆ **Now you will not receive fixed targets for MCH and family planning from higher level.**
- ◆ **Under your supervision the Health Workers will assess the needs of people in the community and estimate services required accordingly and fix their own targets.**
- ◆ **You will ensure involvement of other members/workers working for the same community to assess community needs by way of door to door household surveys and validate the same through consultative process with the members of consultative group.**
- ◆ **You will plan for supervising the services of sub-centre and submit the same to PHC.**





## ***PREPARATION OF SUB-CENTRE ACTION PLAN***

### **LEARNING OBJECTIVES:**

With the help of this unit, you should be able to:

- Compare the estimated requirement of services and resource requirement based on consultative process with those estimated with demographic calculations.
- Prepare a work plan for providing all estimated services.
- Prepare plan for carrying out the activities in each village covered under sub-centre.
- Fill the Annual Action Plan form provided by GOI.

### **CONTENTS:**

- What an Action Plan means
  - How to prepare an action plan. Under your supervision the health workers will carry out the following:
    - i. Mapping of area covered under sub-centre
    - ii. Conducting household survey.
    - iii. Holding of consultative meeting with community representatives
    - iv. Estimation of requirement and work load
    - v. Identifying high-risk groups and prioritization thereof.
    - vi. Comparing estimated requirements with demographic calculations.
- Work plan for Health Assistant (Male)

## **1.5 INTRODUCTION:**

Sub-centre action plan is the first step in the process of planning for a district. It provides a basis for determining the health care needs of the people for an area, particularly of a sub-centre. Hence, you should be able to assess the needs of the sub-centre area in a realistic way, set feasible norms accordingly for each service and ensure that a plan is made for provision of the required services.

## **1.6 WHAT IS AN ACTION PLAN?**

A document mentioning activities to be carried out in a specified time-frame indicating the resource requirements, timetable and place/venue for each action is referred to as 'Action Plan'.

Hence, for preparation of action plan you will ensure that the male health worker identifies the tasks to be performed so as to provide the needed services, assess the requirement of resource for each service and prepare a timetable for carrying out such activities.

## **1.7 HOW TO PREPARE AN ACTION PLAN?**

Under your supervision and leadership, the health workers will take the help from members of the village working team on the steps mentioned below. You have to ensure that they follow all the steps correctly.

- 1. You have to ensure that the health workers prepare the Map of Sub-centre and its area. You have to make sure that they*
  - Identify villages to be covered by the sub-centre.
  - Take help from AWWs, TBAs, MSS members and other male health functionaries etc. from each village and prepare a map of entire sub-centre area.
  - Identify community resources available in the sub-centre area (Place for conducting group meeting (public/private),



transport facility for referral, people who can help organising various camps etc).

2. *You have to provide supportive supervision in conduction of household survey to collect the following relevant information required as per the format prescribed by MOHFW such as: (Reference period last and current year)*

- Number of eligible couples (ECs).
- Number of pregnant mothers.
- Number of pregnant mothers registered.
- Number of pregnant mothers given full doses of TT.
- Number of births.
- Number of births registered.
- Number of home deliveries.
- Number of home deliveries conducted by TBAs.
- Number of deliveries conducted by ANM/LHV.
- Number of deliveries conducted at PHCs/CHCs/Govt. hospitals/nursing homes.
- Number of deliveries conducted by private practitioners.
- Number of pregnant mothers referred as high-risk cases.
- Number of pregnant mothers who developed any kind of complications.
- Number of abnormal deliveries.
- Number of abortions.
- Number of low birth weight babies born.
- Number of newborns who had difficulty in breathing immediately after birth.(Did not cry immediately).
- Number of Neonatal deaths occurred.
- Reasons for Neonatal deaths.
- Any stillborn baby delivered.
- Number of children up to 1 year of age.
- Number of children below 3 years of age.
- Number of children below 5 years of age.
- Number of children who had very frequent episode of diarrhoea.
- Any child referred due to dehydration.
- Number of children who had frequent attack of ARI.

- Number of children referred to PHC/Hospital for treatment of pneumonia.
- Number of children suffering from malnutrition.
- Number of children going to AW Centre.
- Number of children completely or fully immunised.
- 0 –1 year
- upto 3 years
- upto 5 years
- Number of women using oral pills.
- Number of women got Cu 'T' inserted.
- Number of women who had undergone MTP.
- Number of couples using condom.
- Number of women who had accepted sterilization (Tubectomy).
- Number of men who had undergone vasectomy.
- Number of women having signs and symptoms of RTI/STI.
- Number of women / couples taking any treatment for RTI/STI.
- Number of adolescents – (i) Girls ( 10 to 19 years )
- (ii) Boys (10 to 19 years)

You must ensure that the male health worker assists the female health worker and the village working group members while conducting the household survey and update the Eligible Couple Register.

3. *Ensure that the health workers conduct group - meetings for consultation with the working team members and other members including Panchayat members, school teachers, priests etc. Share the information collected by household survey, ask for more information and validate the same.*
4. *Make sure that they set priorities, fix workload for each service as per identified needs*
5. *Make sure that they identify high-risk groups.*
6. *They should be able to estimate workload and resource requirement for each component of the services and prepare a plan of actions by*



*indicating details of fixed days and time for each service, strategies for providing these services such as by conducting clinic at sub-centre headquarters or at other villages of sub-centre area and home visit for out reach services (venue should also be fixed - Panchayat Bhawan, AW centre, School, Temple etc. for conducting clinics at other villages). The details to this effect are given under work plan of this unit.*

Immunization sessions/clinics are always held on fixed date and venue. The details to this effect are given under work plan of this unit.

You must compare the requirement worked out through survey and consultative process with actual achievements of the previous year and ensure that these are 5-25 per cent higher than the previous year. Increase of less than 5 per cent indicates under estimation and more than 25 per cent indicates unrealistic assessment of current year's requirement.

7. *You should also compare these with demographic calculations and help the health workers to validate the information collected through house hold survey and consultative process.*

For example:

For estimation of probable number of pregnancies that may occur, the formula that could be used is as follows:

**Probable number of pregnancies = Population of the area x Birth rate of the area + 10 percent for pregnancy wastage**

**Or to say:**

**The population of the sub-centre being 5000**

**If the Birth rate of the district were 30 per 1000 population then the calculation would be as follows**

$$(A) \quad \text{Population} \times \text{Birth Rate} = \frac{5000 \times 30}{1000} = 150$$

Add 10 per cent of (A) for pregnancy wastage i.e.,  $150+15=165$   
(10% of 150=15)

(The estimates based on the State or District statistics will be more precise and should be used for planning for sub-centre area. This information would be available with the MO (PHC) who would collect this information from District Statistical Officer/District Family Welfare Bureau.

The number of pregnancies will also indicate the **probable number of deliveries** that are expected in a sub-centre. This would also be the target of **antenatal registration**. Accordingly, the number of ANC visits, requirement of T.T doses, IFA tablets can be worked out.

It has been estimated that 15 per cent of antenatal mothers registered are usually high-risk cases. Thus to work out the number of high-risk mothers in a sub-centre area, this percentage should be compared with your estimation of this figure.

For example:

(Birth rate Services being 30 per 1000 and 5000 being the population of a Sub-centre )

AN Registration (within 16 weeks)	100% of the pregnant mothers to be registered i.e. 165
--------------------------------------	---

Detection and referral of high risk pregnancies (i.e. 15 %)	$\frac{165 \times 15}{100} = 25 \text{ (Approx.)}$
---	--

Detection and treatment of anaemic mothers (i.e. 50 %)	$\frac{165 \times 50}{100} = 83 \text{ (Approx.)}$
--	--



**T.T. to AN mothers      165 X 2    = 330 (i.e. 100%)**

It has also been estimated that 50 per cent of antenatal mothers are usually anaemic. Hence, you should compare your estimated number of anaemic pregnant mothers with 50 per cent of ante-natal mothers registered. Some of the demographic calculations in these aspects would be as follows:

**Formula used for calculation of number of live births is:**

**Number of live births = Population of the area x Birth rate of the area**

Around 10 per cent of live births are estimated to be sick or high risk who would need referral. For estimation of infants to be immunized in the coming year it is necessary to estimate number of infants alive at last year. (IMR of the district can be used for calculating number of infants who died during the year)

**For example:** Suppose the Infant Mortality Rate (IMR) in your district is 75/1000 live births,

If the total number of live births are 150 then out of 150 live births, the no. of infants who would probably die before one year of age  
$$= 150 \times \frac{75}{1000} = 11 \text{ (approx.)}$$

The number of children below 3 and 5 years of age could be calculated by taking 8 per cent (for below 3 years) and 13 per cent (for below 5 years) respectively of total population of the area. However, the requirement assessed on the basis of household survey and the figures worked out by the demographic calculations should not be treated as final one. It is desirable that these requirements assessed should be further cross-checked with all the members of CNA team involved including the ISM practitioners and local functionaries.

For example:

In a given population of a sub-centre (i.e. 5000) the number of children below 3 and 5 years age group would be as follows:

Children below 3 years of age can be estimated by considering 8 per cent of total population i.e.  $8 \times 5000$

$$\frac{\text{-----}}{100} = 400$$

Children below 5 years of age constitute 13 per cent of the population i.e.  $13 \times 5000$

$$\frac{\text{-----}}{100} = 650$$

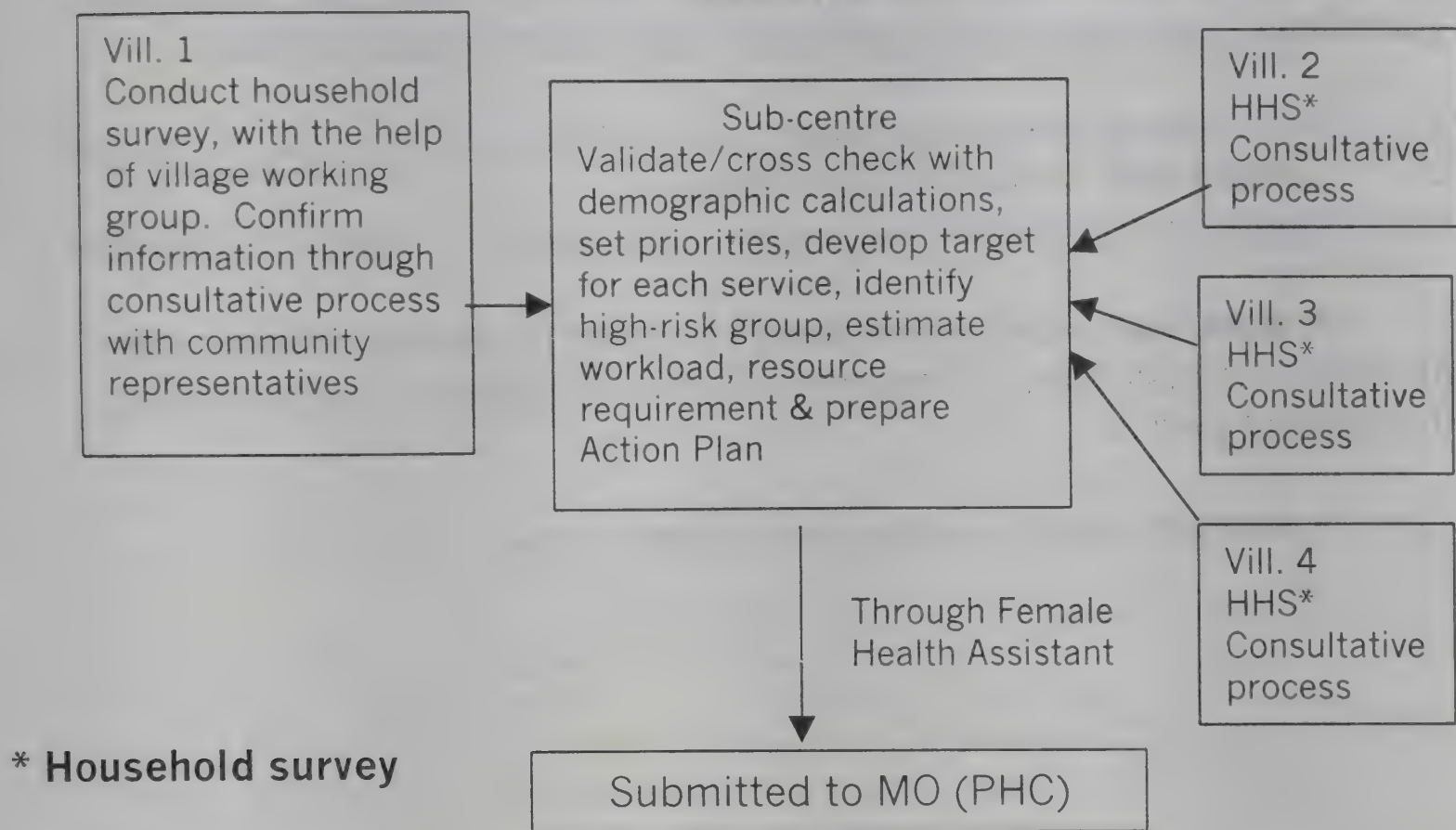
All the subcentre plans are compiled at PHC and the services provided at PHC are added to that. This makes the PHC action plan. You may be asked by the MO I/C of the PHC to help in the process of compilation and finalisation of PHC plan.

### **Steps in Preparation of Action Plan**

- ◆ Ensure preparation of map of sub-centre and its catchment area
- ◆ Supervise conduction of CNA through Household Survey
- ◆ Supervise conduction of group meetings for consultation with the other working members and village representatives (Panchayat members, teachers, priests etc.)
- ◆ Compare these estimates with demographic calculations
- ◆ Make sure that the Male Health Workers sets priorities and develops target for each service as per identified needs
- ◆ Ensure identification of high-risk groups.
- ◆ Estimate workload, resource requirement for each component and ensure preparation of an action plan.



## FLOW CHART FOR PREPARATION OF ACTION PLAN AT SUB-CENTRE



### 1.8 WORK PLAN:

After you have reviewed with health workers, community leaders and the MO (PHC), you are ready to make a work plan. A work plan lists activities you intend to carry out to meet the work objectives.

Having the relevant information regarding catchment area, the distance of each sub-centre from Primary Health Centre and the mode of travel available, type of population, community needs, risk factors, priorities set, you are expected to prepare a work plan for your own convenience as well as for information of community members. You should start with listing types of services needed in each village of the sub-centre and earmark fixed days in a week for supervising those services. This would enable the community members to know where and when Health Assistant (Male) would be available to them.

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In Family Planning clinics of each sub-centre, you have to ensure that the male health worker carries out the following activities:

- a. Advocacy of contraceptives
- b. Gender and Sexuality counselling
- c. Condom distribution

A work plan may be prepared as monthly, weekly or even daily as time and task plan. It enumerates the activities to be performed during that period.

A sample monthly work plan is given below:



**SAMPLE WORK PLAN FOR HEALTH ASSISTANT (MALE)**

NAME OF HEALTH ASSISTANT (MALE) \_\_\_\_\_ MONTH \_\_, 1999

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
1 Sub-centre A Visit with HW(M) Topic : FP	2 Sub-centre B School Health Primary School VI	3 Sub-centre C Visit with HW(M) Topic : FP	4 Sub-centre C Immunization	5 Sub-centre D Visit with HW(M) Topic : FP	6 Preparation of materials for panchayat meeting at community A
8 Sub-centre A School Health Primary School III	9 Sub-centre B Visit with HW(M) Topic :FP	10 Sub-centre C Visit with HW(M) Topic :Malaria	11 Panchayat meeting at community A	12 Sub-centre D Visit with HW(M) Topic : Malaria	13 Planning for leaders orientation camp at Sub-centre A
15 Sub-centre A Visit with HW(M) Topic : Malaria	16 Sub-centre B Visit with HW(M) Topic : Malaria	17 Sub-centre C School Health Primary School IV	18 HOLIDAY	19 Sub-centre D Visit with HW(M) Topic :TB	20 Meeting with the working team
22 Sub-centre A Visit with HW(M) Topic :TB	23 Sub-centre B Visit with HW(M) Topic :TB	24 Sub-centre C Visit with HW(M) Topic : TB	25 FP camp at PHC	26 Sub-centre D School Health Pr. School IV	27 Meeting with Health Assistant (Male) to coordinate work plan for next month
29 Sub-centre A Topic: Immunization	30 Sub-centre B Topic: Immunization	31 PHC Staff meeting, monthly reports, indents			

## 1.9 ADDITIONAL ACTIVITIES TO BE PERFORMED DURING VISITS TO VILLAGES:

**Meet the members of the Panchayat:** This would enable you to develop rapport with the opinion leaders. This would help in mobilisation of community resources in promotion of male participation in the family welfare programme. You should plan such meeting along with the health assistant (female).

**Meeting with the working team:** You must listen to the views of working team members in such meetings and motivate as well as counsel the women on appropriate health care and contraception methods etc.

### KEY POINTS

- ◆ Ensure that based on information collected through door to door survey and validated in consultation with the community members / leaders, you can estimate the requirement for each service to be provided.
- ◆ Compare the estimated requirement with the performance of previous year and ensure your estimated requirement is 5-25 per cent higher.
- ◆ Compare your estimated requirement for each service with the demographic calculation.
- ◆ Fill up the Annual Action Plan form and submit it to the PHC by 10th of March every year.



## FORM 1

### SUB-CENTRE (S.C.) ACTION PLAN

**A.** General Information \_\_\_\_\_ Year \_\_\_\_\_  
 State \_\_\_\_\_ Population of S.C. \_\_\_\_\_  
 P.H.C. \_\_\_\_\_ (Birth rate) Distt./State \_\_\_\_\_  
 Sub-centre \_\_\_\_\_ Eligible couples \_\_\_\_\_  
 No. of Villages \_\_\_\_\_ (As on 1<sup>st</sup> April)  
 under the sub-centre

ANC=(Population x birth rate) + 10 %

DELIVERY/LIVE BIRTH=(Population x birth rate)

Sl. No.	Consultation with	No. of Consultation	When consultation made (month of year)
1.	Panchayat or health committee of the Panchayat		
2.	Anganwadi Worker/TBA		
3.	Women in Mahila Swasthya Sangh		
4.	Families on house-to-house basis		

Sl. No.	Service	Performance in last year	Planned performance in current year
1.	<b>Ante-natal Care</b>		
2.	Total ANC cases registered in the area		
3.	No. of high-risk pregnant women detected and referred		
4.	No. of TT doses given		
	TT 1		
	TT 2		
	Booster		
5.	No. of pregnant women with anaemia treated		
	No. of pregnant women given prophylaxis with IFA tablets		

Sl. No.	Service	Performance in last year	Planned performance in current year
6.	<b>Natal Care</b>		
7.	Total no. of deliveries in the area		
	No. of home delivery by		
	a) ANM/LHV		
8.	b) Trained birth attendant		
9.	No. of institutional deliveries		
	No. of pregnant women referred to PHC/FRU for delivery		
10.	<b>Neo-Natal Care</b>		
	No. of sick newborns referred		
11.	<b>MTP</b>		
	No. of women referred for MTP		

Sl. No.	Service	Performance in last year		Planned performance in current year	
		Male	Female	Male	Female
12.	<b>RTI/STI</b> No. of cases detected and referred				
13.	<b>Immunisation</b> No. of infants immunised (0-1year)				
	BCG				
	DPT-1				
	DPT-2				
	DPT-3				
	OPV-0				
	OPV-1				
	OPV-2				
	OPV-3				
	Measles				
14.	No. of children immunised (more than 18 months)				
	DPT Booster				
	OPV Booster				
15.	No. of children immunised (more than 5 years)				
	DT				
16.	No. of children immunised (more than 10 years)				
	TT				



Sl. No.	Service	Performance in last year		Planned performance in current year	
17.	No. of children immunised (more than 16 years) TT <b>IFA</b>				
18.	No. of children given IFA small (below 5 years)				
19.	No. of children administered Vit-A (9 months to 3 years) Dose 1 Dose 2 Dose 3-5				
20.	<b>ARI</b> No. of cases under 5 with pneumonia - Treated with cotrimoxazole - Referred				
21.	<b>Acute Diarrhoeal Diseases</b> No. of cases under 5 - Cases treated with ORS - Referred				
22.	<b>Family Planning</b> No. of eligible couples who accepted permanent methods out of couples with a) 3 or more children b) 2 c) 1 child				
23.	No. of eligible couples who accepted temporary methods - IUD - Oral Pills - Condoms				





## ***MANAGEMENT OF DRUGS, VACCINES AND OTHER SUPPLIES***

### **LEARNING OBJECTIVES:**

With the help of this unit, you should be able to:

- ▣ Guide the Male Health Worker to estimate quantity of drugs and vaccines required at sub-centre level based on action plan prepared.
- ▣ Ensure procurement of drugs and vaccines in right quantity and at right time.
- ▣ Ensure storage of drugs, vaccines and other materials properly till their utilisation.
- ▣ Supervise maintenance of equipments supplied to sub-centre level.
- ▣ Oversee maintenance of stock-register for all items issued to sub-centre by PHC.

### **CONTENTS:**

- ▣ Estimation of requirement of vaccines.
- ▣ Estimation of requirement of ORS and other drugs.
- ▣ Procurement of drugs and vaccines from PHC.
- ▣ Storage of drugs and other materials.
- ▣ Maintenance of all equipments made available to sub-centre.
- ▣ Maintenance of Stock register.

## **2.1 INTRODUCTION:**

Since there are no fixed targets imposed from the higher levels, you are expected to estimate service needs of the RCH programme for the community falling within the area of your supervision. Also the emphasis should be on quality of services e.g. how many of the children are fully immunised, rather than on quantity of services. You need to prepare indent for drugs, vaccines and other materials that would be required towards the provision of estimated services. Estimation of drugs etc. followed by indenting of right quantity of each drug, vaccine and other materials is absolutely essential to ensure continued availability of such items at sub-centre level for providing services to assigned community members on regular basis. You must ensure that there is no surpluses and wastage of the same. Once the annual requirement of the items mentioned earlier, are estimated and submitted to the controlling PHC, the mechanism of ensuring timely supply of needed items and materials should be worked out based upon the prevalent procedures and practices of supply under RCH Programme (once or twice every year). The demand made should match with the sub-centre action plan under your supervision. However, replenishment should be arranged as and when needed. It may be even earlier than scheduled time in the case of exhausted stock or stock out situation. This module will help you to prepare estimation of material resources needed in right quantity, procure the same at right time and store them properly before being put to use. Maintenance of other equipments provided at sub-centre also needs your attention so as to ensure their prolonged use. You must ensure that health worker (male) maintains a stock-register for all the drugs, vaccines and material received and used at sub-centre level. The correct demand estimation, procurement, timely replenishment, storage and maintenance of supplies and their related records are essential aspects of material management.

### **Management of drugs and vaccines at sub-centre level includes:**

- Estimation of required quantity of the drugs and vaccines needed for provision of services.



- Procurement of drugs and vaccines in right quantity and at right time.
- Proper storage and judicious use of drugs and vaccines.

Even though you are still getting ready made packet of drugs, materials and vaccines as per estimated requirement for each immunization session, you should be able to calculate the requirement as per your number of beneficiaries identified by you while preparing Action Plan through CNA Process.

## 2.2 ESTIMATION OF VACCINE REQUIREMENT :

While overseeing calculation of the requirement of vaccines you should consider the factors mentioned below:

- Number of beneficiaries
- Number of doses of each vaccine
- Wastage and multiplication factor
- Number of sessions

The estimated requirement of various types of vaccines as worked out by you can be further verified with the calculations arrived at by using demographic rates.

The correctness of estimates of vaccines worked out by you should be discussed with MO of the PHC. These estimates are to be finalised after the MO is satisfied keeping in view the total requirement of area, past performance and local situation.

For example: As per the model used earlier for Action Plan.

**Sub-centre population = 5000**

**Vaccines:**

Number of pregnant mothers	= 165
(2 doses of Tetanus Toxoid for each pregnant mother)	= 330 (Approx.)

**Infants alive at 1 yr. of age** **= 139**

**OPV & DPT doses to be administered**  $139 \times 4$  **= 556**  
(4 doses for each child, 3 doses and 1 dose at 16-24 months)

**OPV / DPT doses required**  $- 556 \times 1.33$  **= 740 (Approximate)**  
(Wastage multiplication factor = 1.33)

**BCG / Measles doses to be administered** **= 139**  
(BCG / Measles doses required  $139 \times 2$ ) **= 278**  
(Wastage Multiplication factor = 2)

(The vaccines are supplied in 5, 10 or 20 dose vials or ampules. To calculate the number of vials required, number of doses are divided by 5, 10 or 20 and rounded off to the next 5, 10 or 20 as per the number of doses per vial. The quantities thus calculated would be for the whole year).

The calculation for vaccine requirement will have to be done on the basis of number of sessions planned for each month. With more number of sessions additional vaccines would be required as for each session a new vial is required to be used.

### **Requirement of Vit A concentrated solution**

All children below 1 year of age will require 1 dose of 1 lakh unit  
All children between 1-3 years of age will require 4 doses each of 2 lakh unit

Therefore, the total requirement of doses will be - 139 doses of 1lakh units and 1044 doses of 2 lakh units.

(If number of children below 1 year of age = 139 and between 1 to 3 years of age = 261)

However, requirement of vaccine for conducting an Immunization session is given in Child Health block, which you can refer for organizing each Immunization session.



## **Iron and Folic Acid Tablets:**

For Pregnant mothers:

Number of pregnant mothers registered - 165

100 Tablets for each mother - 16500 tablets

50 per cent of the mothers expected to be anaemic and would need double the dose i.e 100 additional for each.

That is  $165/2 \times 100 = 8250$

Hence, the total requirement of Iron and Folic Acid Tablets would be:  
 $16,500 + 8,250 = 24,750$  tablets

## **Iron and Folic Acid (small) for children:**

IFA small tablets are meant for children between the age of 1 to 5 years, who show visible signs of anaemia. Each child is to be given 1 tablet/day for 100 days.

- a. if the number of children (1-5 years) is 500 (approx.)
- b. Number expected to show visible signs of anaemia (50%) = 250
- c. Requirement of IFA (small) is  $(250 \times 100) = 25,000$ .

## **ORS Packets:**

A child under 5 years of age suffers on an average 3 episodes of diarrhoea every year. Thus, there will be  $650 \times 3 = 1950$  episodes of diarrhoea every year in a sub-centre area. [If Number of children below 5 years of age = 650]. One packet of ORS is required for each episode. That means 1950 packets will be required for these children. However 10% of these episodes are with dehydration which would require an additional packet of ORS. That means 195 episodes (10% of 1950 episodes) will require 195 more ORS packets. Thus, the total requirement of ORS packets in every year will be:  $1950 + 195 = 2145$  packets

However, all the children may not report for each episode. In view of the past performance, MOHFW supplies a certain quantity. In case you fall short, you can always ask for more packets from

PHC. Sudden increase in reporting and consumption of ORS packets is an alarming sign to you for anticipating epidemics of diarrhoeal diseases.

### **Cotrimoxazole Tablets (Paediatric):**

The total episodes of Acute Respiratory Infection (ARI) at the rate of 3 episodes per child under 5 years in a year would be equal to diarrhoeal episodes of 1950 cases as calculated above. It had been worked out that only 10 per cent of the episodes of ARI are pneumonia requiring antibiotic therapy. Thus, 195 episodes of pneumonia will on an average need 20 tablets of cotrimoxazole (paediatric) each. Hence, the total annual requirement of cotrimoxazole would be  $195 \times 20 = 3900$  tablets. It would be desirable to compare all these estimates with the estimates and actual use of the last year and verify whether the same has increased by 5 to 25 per cent or not.

### **2.3 PROCUREMENT:**

Having prepared estimates, the next step is to fill the Action Plan Form along with the form on 'Inventory of Vaccines and Drugs' and submit the same by 10th of March each year (Along with the Action Plan to the PHC). Comparison between the assessment and actual quantity received and requirement for current year would be visible in the form. There is also a column in the form for listing surpluses or shortages of the last year.. Usually, the drugs and materials would be supplied on quarterly basis and replenished if needed. Stock out must be avoided in all possible manners. You must ensure that there is always stock for one or two months at sub-centre. Larger quantity of stock would indicate either over indenting or non-performance or under utilisation of services.

The supply of vaccine to sub-centre is not done on monthly/quarterly basis. The vaccines are to be procured in the 'vaccine carrier' only on the day of immunization session. The required action to procure additional drugs / vaccines both should be taken well in time and a. List of 'Inventory for Drugs & Vaccines' (See Annexure 1.1 available at the end of this unit).



For PHC – Vaccines may be procured for one month requirement and stored for further supply to subcentres.

## **2.4 STORAGE:**

### **Vaccines:**

You have to ensure that vaccines are not stored at the sub-centre level in any case. These must be supplied from the PHC on the day of use only. The precautions to be observed to keep vaccines safe and potent are as follows:

- Only required quantities for day's consumption during immunization session be procured.
- The vaccine carrier must have frozen ice-packs.
- Immunization must be carried out in the shade and OPV and Measles vaccines must be kept on an ice-pack or in a cup of ice during the session.
- Only one vial of each vaccine should be taken out of the carrier at a time.
- Unused vials must be returned to PHC on the same day.

### **Other drugs:**

- All drugs being supplied, in general, should be kept in a cool dry place protected from direct sunlight, air and moisture.
- The drugs must be stored in respective containers with proper labels.
- The drugs supplied in strips and the ORS packets should be stored in a container/cardboard box. Arrange drugs in bottles/strips in such a way that one with earlier expiry date are in the front, so that these can be used first. The recent supplies received should be placed behind. The principle of first-in – first-out (FIFO) must be followed in true spirit.

- Do not use expired drugs if they have changed colour or there is a change in consistency. Check drugs from time to time.
- Always check the expiry date before use.

## 2.5 MAINTAIN A STOCK REGISTER:

You must check during supervisory visit to a sub-centre that the health workers maintains a Stock Register by making entries with date of supply and quantity received from the PHC. The entries with regard to quantity used daily must be made in column 6 of stock register. At the end of each month, check the balance by way of physical verification. With the information in Column 7, you would get to know the items, which are not consumed and thus would require physical verification.

**Information to be filled in stock register:**

**Name of the drug**

Date	Previous balance	Quantity received	Quantity used	Balance in hand	Expiry date	Remark

## 2.6 MAINTENANCE OF EQUIPMENTS AT SUB-CENTRE LEVEL:

The maintenance of equipments at sub-centre level is done to ensure quality and effectiveness of services provided and satisfaction of the beneficiaries.



## **Vaccine Carriers:**

You have to make sure that the health worker (male) uses 'vaccine carriers' for procuring and carrying small quantity of vaccines (i.e. 16-20 vials) to sub-centre area and its villages. The vaccine carrier is made of insulated material. It should not be cracked or broken. You must ensure that the ice packs for lining the sides of carrier are fully frozen and the lid of carrier is closed tightly. The vials of DPT, DT and TT vaccines should come in direct contact with the frozen ice packs.

You have to ensure that the health worker (male) observes the following precautions before using or packing the vaccines in the vaccine carrier:

- Takes out vaccine carrier and confirms that there are no cracks in its body.
- Takes out the required number of ice packs and wipes them dry. Checks each pack.
- Places fully frozen ice packs in and closes the lid of the carrier and waits for few minutes for temperature to fall to less than 8 degree Celsius.
- Puts vaccine vials and ampoules in a polythene bag and close it.
- Places some packing material between DPT vaccine and the ice to prevent them from touching the ice packs.
- Stocks vaccines and diluent in the carrier
- Closes the lid tightly.

The following points would help you guide the Male Health Worker in ensuring that he keeps the vaccine carriers in good condition when not in use. The health worker (male) must

- Clean and dry inner side of carrier after each use.
- Examine the carrier both from inside and outside after each use for any crack.
- Keep the carrier away from direct sunlight and other sources of sunlight, as this may cause the plastic to crack.

- Do not place anything heavy on vaccine carrier.
- The carriers with four ice packs can keep the vaccines cold for 2 days provided the ice packs used are fully frozen and the lid of carrier is closed tightly.

### **Blood Pressure Apparatus:**

A sphygmomanometer or an aneroid B.P. instrument has been provided to all sub-centres. You must make sure that the health worker (male) uses it for measuring B.P. You must make sure that when the aneroid B.P. instrument is taken out of the case, the dial should be held properly otherwise it might fall and break.

The sphygmomanometer along with the stethoscopes (if available) should be kept in the cupboard free from dust and sunlight. While packing you should take care that the cuff is properly deflated and then folded and the rubber tube is not kinked. When not used for a long time, the rubber tube and the cuff may start softening, particularly in summer and start leaking. You must check this frequently so as to keep the instrument worthy of use.

### **Weighing Scale:**

A weighing scale for adult and a spring/pan balance for babies are provided to all sub-centres. As a Supervisor of sub-centre staff, you should ensure that these equipments are maintained properly. The weighing scales must be kept in the cupboard. You must periodically check the same for zero error by weighing a known weight (Measure). Take adequate precautions to ensure that the spring balance does not get rusted.

### **MANAGING EQUIPMENTS:**

There are two types of equipment and materials supplied to PHC for providing services. These are consumable or expendable and capital or non-expendable. Consumable equipment is that which is used within a short time. These are also called as recurring



equipment or material. Non expendable or capital equipment is such equipment, which lasts for several years and used repeatedly. These are also known as non-recurring equipment. These need care and maintenance for extending its use for long time. For example – Furniture, Refrigerator, Ice-lined Refrigerator (ILR), vaccine carrier, weighing scale, sphygmomanometer, instruments, vehicle etc. Consumable equipment includes material like cotton, gauge, bandage, chemicals, syringe, needles, etc. The management of these including estimation of each item required, placing an indent and procuring that from District Head Quarter, and proper storage is equally important as of drugs.

Hence, you have to prepare an estimation of each item based on services planned for the coming year. You must compare this estimation with the consumption during previous year and ensure that it is at least 10% higher than that.

These items are usually supplied quarterly or on half yearly basis. However, you can get replenishment earlier if your stock gets exhausted. Try to ensure economic use of material to avoid wastage or over use and establish a control mechanism to prevent pilferage.

### **Storage of Equipments:**

Equipment is stored in two places:

- A main or reserve store - (Stock of usable but idle items (i.e. the items waiting to be used).
- At the place of use.

The new items of equipment are received and stored in main store.

### **Receiving new items of equipment (Non-expendable/capital):**

A new item is usually delivered along with a document of specifications of the equipment. Since you get the new items

delivered from District Head Quarter, you usually do not have to make the payment which is done at the place of purchase. Some of the equipment will be centrally purchased at Centre or State Government Level and supplied to you through District Level Authority. You only have to ensure that you are provided with the right type of equipment and it is in functional condition.

**PHYSICAL VERIFICATION AT THE TIME  
OF RECEIVING THE NEW EQUIPMENT IS  
VERY IMPORTANT AND ESSENTIAL FOR  
YOU**

After receiving the equipment, enter it in the stock-book or ledger, which usually has a separate page for each item. Ensure that the following items of information are entered in the ledger:

- The date of receipt of the item.
- The reference number of the item
- The quantity of items received.

When you issue an item for use subtract it from the stock and calculate the balance remaining in the stock. When the balance reaches to a certain point of quantity, it indicates that it is time to order for replenishment. This order is referred as Re-order level. For each item, you must have the re-order level indicated to help you to prevent 'stock out' position.

### **Controlling and Maintaining equipment:**

As mentioned earlier recurring/consumable items must be used economically to avoid wastage to the possible extent. You must establish a system, which will help you in avoiding wastage of consumable items and maintaining capital or non-expendable items in good working conditions.



You need to practice the following skills:

- a. Convincing staff of the importance of maintenance, so that they realise that equipment must be cleaned, inspected and kept in good order. They should report defects immediately as soon as noticed and they must return the equipment to its correct place after use.
- b. Using of inspection checklist and inspection schedule. You must inspect the equipment by checking using checklist what is present and compare with the stock position. Inspection schedule is prepared based on frequency of checking needed. How often you should check an item depends on whether it is consumable or non-consumable. Consumable items need to be checked more frequently than non-consumable items like Furniture, Refrigerator etc. However, non-consumable but delicate items which are liable to breakdown easily like Sphygmomanometer, electric sterilizers, microscopes etc need regular and more frequent check ups. In order to avoid missing this task, you must prepare an inspection schedule and fix up day/date and time for checking up of the equipment.
- c. Detecting and interpreting discrepancies: Discrepancy means difference between what is expected to be there and what is actually there. The difference between the amount of a consumable items used and the amount normally is expected to be used or a difference between the equipment entered in the inventory ledger and the equipment actually present must be detected and reasons identified for taking appropriate actions.
- d. Demonstration of handling & functioning of the existing and new equipments received.

**DETECT DISCREPANCIES, FIND  
THE CAUSE OF DISCREPANCY  
AND TAKE APPROPRIATE ACTION**

## **Maintenance of some important equipment:**

**Equipments for Cold Chain:** Required for prevention of deterioration of vaccine.

The equipment used for maintenance of cold chain for vaccines is considered an important equipment for PHC as well as sub-centre.

At sub-centre level, since no vaccine has to be stored, only 'vaccine carriers' are used. For storage of vaccine at PHC level the following equipment are provided which need to be maintained and properly used.

- a. Ice-lined Refrigerator (ILR)
- b. Deep Freezer
- c. Cold Box.

### **Ice Lined Refrigerator:**

ILRs are top opening refrigerators. Under the National immunization programme, two types are in use, one with ice tubes and the other with ice packs as the ice lining. These act as a buffer in case of power failure by preventing a rise in temperature inside the refrigerator.

The bottom of these refrigerators is the coldest place. DPT, DT and TT vaccines should not be kept directly on the floor of the refrigerators as they can freeze and get damaged.

**KEEP BCG, DPT, DT AND TT  
VACCINES IN THE BASKET  
PROVIDED WITH THE  
REFRIGERATOR**



Keep the dial thermometer inside the ILR to record the daily temperature even if there is an in-built thermometer.

There is **NO FREEZER COMPARTMENT IN THE ILRs**. You cannot freeze ice packs or ice in the ILRs.

Temperature of ILR/Freezer should be recorded twice daily. This should be done by the identified person responsible for storage and issue of vaccines. The Medical Officer should check the record regularly. The break in the cold chain is indicated if temperature rises above +8°C or falls below +2°C.

The Electrolux type of ILR can also be used as a deep freezer also by changing the switch to the appropriate position. [There is no such arrangement in Vestforst ILR. In case of Vestforst, a Deep Freezer is supplied separately.] In an emergency, if you wish to prepare ice packs in these ILRs, you must switch it on to work as a freezer. But before you do this be sure that you have transferred DPT, DT, TT and other vaccines that are damageable at sub-zero temperature to another refrigerator or to an already prepared Cold Box. The Cold Box must have the required number of solidly frozen ice-packs and the vaccines should be in polythene/cardboard boxes before transfer.

Ordinarily, ILRs must be used only as a refrigerator for storing vaccines even when there is another refrigerator in your PHC. The risk of cold chain failure is far less in an ILR than in a conventional refrigerator specially where there are periodic power failure. However, in some PHCs where the ILR has not been supplied as yet, the vaccines may be stored in a conventional refrigerator till an ILR is received.

## THE DO's AND DON'Ts FOR USE OF ILR/FREEZER

*Exhibit 2.1*

### **DOs**

- Keep the equipment in a cool room away from direct sunlight and at least 10 cms away from the wall.
- Keep the equipment level.
- Fix the plug permanently to the socket.
- Use voltage stabilizer.
- Keep the vaccines neatly with space between the stacks for circulation of air.
- Keep the equipment locked and open it only when necessary.
- Defrost periodically (detailed subsequently).
- Check the temperature twice a day and maintain a record which should be supervised regularly.
- Take remedial action if the temperature is not maintained within the prescribed limit.
- Outside the equipment paste a notice that helps the user during a break down
  - whom to contact and where to check for a blown fuse.
  - Alternate place for vaccine storage.



**DONTs**

- Do not keep drugs
- Do not open the door/top unless necessary.
- Do not keep food or drinking water in the refrigerator.
- Do not keep anything for more than one month time in the refrigerator.
- Do not keep more than one month's requirements.
- Do not keep vaccines which are expired.

**FOLLOW FIRST-IN-FIRST-OUT-RULE**  
Vaccines with an early expiry date or received earlier should be used first.

**ILR/FREEZER CHECK LIST FOR PREVENTIVE MAINTENANCE**

<b>a. External</b>	<b>Remarks</b>
<ol style="list-style-type: none"> <li>1. The exterior is clean.</li> <li>2. It is firm on the floor</li> <li>3. It is properly leveled</li> <li>4. Its sides are minimum 10 cm away from any wall or object.</li> <li>5. The room is well ventilated.</li> <li>6. Lid is kept locked</li> <li>7. Keys kept at easily available place.</li> </ol>	
<b>b. Internal</b> <ol style="list-style-type: none"> <li>1. Lid seals properly without gap</li> <li>2. Lid seal is clean</li> <li>3. Ice-lining tubes/ice packs are in proper position (for ILR only).</li> <li>4. Ice lining tubes/ice packs filled to proper level (no leak).</li> <li>5. Thickness of frost formation is not more than 6 mm</li> <li>6. Vaccines preserved in neat rows.</li> <li>7. There is space between rows for air circulation.</li> <li>8. DPT and TT vaccines are kept in the basket and not touching any cooling surface (for ILRs only).</li> <li>9. Separate dial/stem thermometer kept among the vaccine.</li> <li>10. Reading of dial/stem thermometer.</li> </ol>	



c. Technical	Remarks
<ol style="list-style-type: none"> <li>1. Reading on the built-in thermometer of the equipment.</li> <li>2. Thermostat setting.</li> <li>3. Temperature indicated is within specified range. (if not, adjust thermostat to obtain steady temperature within specified limits.  Note : Present thermostat setting _____).</li> <li>4. Voltage stabilizer connected.</li> <li>5. Input voltage reading _____ volts.</li> <li>6. Output voltage reading _____ volts.</li> <li>7. Plug of voltage stabilizer fits properly and not loose on the power socket.</li> <li>8. Connections of equipment to voltage stabilizer proper and not loose.</li> <li>9. Compressor compartment and the components inside are clean.</li> <li>10. Electrical connections are proper</li> <li>11. No abnormal noise</li> <li>12. Cooling fan (if any) works properly.</li> <li>13. Compressor and fan mounting bolts are tight.</li> <li>14. Pipe or components are not out of position and not touching others</li> <li>15. Temperature recorded is minimum twice a day.</li> </ol>	

**NOTE: FOR ANY 'NEGATIVE' ANSWER, TAKE ACTION.**

## **Deep Freezer**

It is also a top opening equipment. It is to be used for storing polio and measles vaccine and freezing of ice-packs. A pair of Deep Freezer (140 litre) and a Vestforst ILR (140 litre) is connected to a common voltage stabilizer. Do not store BCG and T series vaccines in the deep freezer.

### **Defrosting and cleaning:**

The temperature in the ILR/Freezer can rise if there is a thick layer of ice around the freezer or along the walls and bottom of ILRs. It is therefore necessary to defrost them periodically. This should be done if the ice in the freezer is more than 6 mm thick.

As a supervisor, you have to ensure that the Deep Freezers/ILRs are regularly defrosted and cleaned. The following points should be observed:

- Power supply needs to be switched off and the plug removed from the wall socket
- Vaccines need to be transferred to the Cold Box (or another ILR) for temporary storage. In case of Freezer, take the frozen ice-packs out and keep them in a cold box or close together.
- Open the defrost water outlet plug at the bottom of the cabinet. Keep a suitable container under the drain hose to collect the defrost water.
- Keep the lid open and allow the frost to melt completely. Never use any heat source other than warm water to speed up defrosting. Never use any sharp edged instrument for removing frost or for cleaning.
- Wash all parts inside the cabinet with warm water and mild detergent, wipe it dry with clean cloth. Never use any strong detergent or rubber reactive material for cleaning the rubber seal.
- Allow the cleaned parts to dry completely. Rest the drain outlet plug at its position at the bottom, close the lid. Connect the power supply plug to the wall socket.



- Turn the thermostat knob to right (clockwise) to maximum position. Observe the temperature and reset.

**THE LID OF A FREEZER/ILR MAY BE STUCK IMMEDIATELY AFTER CLOSURE FOR A FEW MINUTES DUE TO NEGATIVE PRESSURE. DO NOT FORCE OPEN THE LID. WAIT FOR A FEW MINUTES AND TRY AGAIN. LID WILL OPEN EASILY.**

## **COLD BOXES**

Cold boxes are big insulated boxes. They come in two sizes, 5 litres and 20 liters. They are supplied with requisite number of ice packs. The 5 litre cold box can hold one month vaccine supplies of a PHC of 30,000 population. 20 litre cold box has enough space to transport one month supply of health centre catering for one lakh population.

### **USES:**

- Collect large quantities of vaccines.
- Transport large quantities of vaccine by vehicle to outreach sites.
- Store vaccines for transfer upto five days, if necessary for outreach session or when there is power cut. The hold over time is more than 90 hours at + 43°C ambient temperature. You can also store vaccines in it while ice packs are being prepared in Electrolux ILR on Freezer mode.
- Store vaccine in case of breakdown of ILR.

### **TO PACK:**

- Place fully frozen ice packs side by side against the inside walls and floor of the cold box.
- Stock vaccine and diluent in the box.
- Place packing material between DPT/DT/TT vaccine and the ice pack to prevent vaccine from becoming frozen.

- Place ice packs over the top of the vaccine and diluent.
- Secure the lid tightly.

### **TO KEEP IN GOOD CONDITION WHEN NOT IN USE:**

- Clean and dry after every use.
- Examine inside and outside surfaces after every use for cracks.
- Check that the rubber seal around the lid is not broken; if broken, replace immediately.
- Adjust the tension on the latches so that the lid closes tightly.
- Lubricate hinges and locks routinely.

### **COLD CHAIN EQUIPMENT AT SUB-CENTRE:**

#### **Vaccine Carriers:**

You can use 'vaccine carriers' for carrying small quantity of vaccines (i.e., 16-20 vials) to the area and its subcentre villages. The vaccine carriers are made of insulated material. The ice packs for lining the sides of the carrier should be fully frozen and the lid of carrier should be closed tightly. The vials of DPT, DT and TT vaccines should not be in direct contact with the frozen ice packs. Before using or packing the vaccines in the Vaccine Carrier the precautions that need to be observed are as follows:

- Take out vaccine carriers and confirm that there are no cracks in its body.
- Take out the required number of ice packs and wipe them dry.
- Place fully frozen ice packs in the carrier and wait for few minutes for temperature to fall to less than 8 degree celsius.
- Put vaccine vials and ampoules in a polythene bag and close it.
- Stock vaccines and diluent in the carrier.
- Place some packing material between DPT vaccine and the ice to prevent them from touching the ice packs.
- Close the lid tightly.



## **How to keep vaccine carriers in good condition when not in use:**

Some of the tips to this effect are mentioned below:

- Clean and dry inner side of carrier after use.
- Examine the carrier both from inside and outside each after each use for any cracks.
- Keep the carrier away from direct sunlight and other sources of sunlight, as this may cause the plastic to crack.
- Do not sit or place anything heavy on a vaccine carrier.
- The carriers with four ice packs can keep the vaccines cold for 2 days provided the ice-packs used are fully frozen and the lid of carrier is kept closed tightly.

### **KEY POINTS**

- ◆ Ensure correct estimation of the requirement of drugs and vaccines based on estimated quantity of services to be provided/rendered.
- ◆ Make sure that no vaccine is stored at sub-centre level. These should be procured on the same day of immunization clinic/session in a vaccine carrier.
- ◆ Ensure that other drugs are stored in container with proper labels in cool and dry place.
- ◆ Make sure that the Health Worker (Male) does not use any drugs if there is change in colour or change in consistency.
- ◆ Ensure that the Health Worker (Male) maintains a stock register for accounting of used and balance of supplies received.

## INVENTORY OF VACCINES AND DRUGS

Sr. No.	Item	Unit	Requirement assessed last year	Actual quantity received last year	Surplus or shortage last year	Requirement for current year .
1.	ORS Packets					
2.	Metronidazole Tablets					
3.	Cotrimoxazole					
4.	Paracetamol					
5.	Chloroquine					
6.	Antiseptic solution					
7.	Uristix					
8.	DD kits (Disposable Delivery Kits)					
9.	Thermometer					
10.	Gloves					
11.	IFA large tablets					
12.	IFA small tablets					
13.	Vit – A solution					
14.	Condom					
15.	Oral pills					
16.	IUDs					
17.	Syringe and Needles					

**Source:** Manual on Community Need Assessment Approach in Family Welfare Programme, Department of Family Welfare, MOHFW, New Delhi.



## ANNEXURE - I

### CONTENTS OF DRUG KIT (A)

Sr. No.	Name of the Item	Quantity
1.	Oral Rehydration Salt (O.R.S.)	150 packets
2.	Tablet I.F.A. (large)	15000 tablets
3.	Tablet I.F.A. (small)	13000 tablets
4.	Vitamin A solution	6 bottles of 100 ml. each
5.	Tablet Cotrimoxazole (Paediatric)	1000 tablets

**Source:** RCH Programme Schemes for Implementation, Department of Family Welfare, MOHFW, New Delhi.



## CONTENTS OF DRUG KIT (B)

Sr. No.	Name of the Item	Quantity
1.	Tab. Methylergometrine Maleate (0.125 mg.)	500 tablets
2.	Tablet paracetamol (500 mg.)	500 tablets
3.	Inj. Methylergometrine Maleate [0.2 mg/ml., 1ml. ampoule (for I.M. use) in light resistant amber colour ampoules)	10 ampoules
4.	Tab. Mebendazole 100 mg.	300 tablets
5.	Dicyclomine HCl 10 mg.	250 tablets
6.	Chloramphenicol Eye Ointment 1% w/w in applicaps. Each applicap to contain 250 mg. of ointment	500 applicaps
7.	Ointment Povindone Iodine 5%	5 Tubes
8.	Cetrimide Powder	125 gms
9.	Absorbent Cotton	1 roll
10.	Cotton Bandage (4 cms width x 4 metres length)	120 rolls

**Source:** RCH Programme – Schemes for Implementation,  
Department of Family Welfare, MOHFW, New Delhi.



# ANNEXURE – III

## SUB-CENTRE EQUIPMENT KIT

Item description	Qty./Kit	Item description	Qty./Kit
Kit C-sub-centres			
Basin KIDNEY 825 ML(28 OZ) Stainless steel, ref is:3992	2EA	Basin solution deep Approx. 6 litres ss ref is : 5764	• 1EA
Tray instrument/dressing w/cover 310x195x6 mm ss, ref is 3993	1EA	Brush surgeons white nylon bristles	2EA
Flashlight box-type pre- focused 4 cell	1EA	Sphygmomanometer aneroid 300 mm with cuff is : 7652	1EA
Jar dressing w/cover 0.945 liter stainless steel	1EA	Rack blood-sedimentation westergren 6-unit	1EA
Hemoglobinometer-set sahli type complete	1EA	Battery dry cell 1.5, 'd' type for item 10c	4EA
Scale bathroom metric/ avoirdupois 125 kg/280 lb	1EA	Scale, infant metric	1EA
Sheeting plastic clear pvc cm x 180 cm	2 EA	Lancet ss (magedorn needle) 75 mm pkt of 6	1EA
Forceps tissue-160 mm	1EA	Forceps hemostat Straight kelly 140mm ss	1EA
Forceps sterilizer (utility) 200 vaughm ss	1EA	Forceps uterine vulsellum curved 25.5 cm	1EA
Scissors surgical straight 140mm s/b, ss	1EA		1EA
Reagent strips for urine test	1EA	Speculum vaginal bi-valve cusco's/graves medium	1EA
Sims uterine depressor/retractor	1EA	Speculum vaginal double – ended sims : iss medium	1EA
Measure 1 litre jug-ss	1EA	Measure ½ litre jug-ss sound, uterine, graduated)	1EA 1EA





## ***TEAMWORK AND LEADERSHIP***

### **LEARNING OBJECTIVES:**

With the help of this unit, you should be able to:

- ❑ Explain what is teamwork.
- ❑ Supervise constitution of working team at village level.
- ❑ Maintain rapport with the team members and make the team effective.
- ❑ Ensure that the Health Worker (Male) gets involved in organizing meeting with the team members

### **CONTENTS:**

- ❑ Concept of team and teamwork.
- ❑ Village working team
- ❑ Health Assistant (Male) as team leader for village level workers
- ❑ How to make the village working team functional and effective.

### **3.1 INTRODUCTION:**

Provision of appropriate and effective services under RCH programme depends on community need assessment through consultative process. In order to provide client specific services based on user choice, you have to estimate the need of community members and decide on requirements of services accordingly. You

as an individual can not do it all alone, rather you will have to depend on workers of other sectors who are also working for the same community. Since, you and all these workers are working for the same community, it will be better if you can join together in the efforts and make them understand to work together in a team. You being technically trained and competent person on various components of health and family welfare services, it is basically your responsibility to ensure adequate and appropriate provision of services for the area of sub-centres. Accordingly, you will have to shoulder the responsibility of bringing all the workers under a common umbrella so as to work together. Nevertheless, you would be required to provide guidance and support to such workers including the Male Health Workers and take their help in carrying out your activities properly. Hence, the health workers are expected to develop a working team, which would function under your supervision. With the help of such working team, it might be possible for you to supervise community meeting for consultative process and make arrangements for required RCH services through clinic as well as outreach approach.

### **3.2 CONCEPT OF A TEAM:**

A team is a group of people who must significantly relate with each other in order to accomplish commonly shared objectives. All these workers/members, working at the village level, have a common interest i.e. 'Development and Welfare of a Common Community Members.'

### **3.3 TEAMWORK:**

Teamwork is defined as *"work done by a number of associated individuals/workers who are committed and agreed to in doing the work assigned or otherwise"*. In this process, each person in the team does a part of work and this part is coordinated with the efforts of others. Teamwork is understood as continuous condition of working together with others, individually and collectively in the common interest of group. Hence, teamwork does not occur accidentally but



needs to be built up by conscious as well as concrete efforts and by analysing the behavior of its members.

Effective teamwork basically depends on commonality of purpose or common interest. The capable and effective leadership is the most crucial aspect of teamwork. You need to guide and supervise the health workers to develop a separate working team, for each village forming the part of their sub-centre area.

**The Village working Team:** In each village the **working team** must consist of the following members:

1. Health Worker (Female and Male)
2. Anganwadi Workers
3. Traditional Birth Attendants/Dais
4. MSS /ISS Members
5. Woman member of village Panchayat

Besides these, if the following persons/groups exist, they should also be included to participate in the health team

6. DWACRA group leaders, if any
7. Link persons, if any

You have to ensure that the Health Worker (Male) and the helper at sub-centre level in the village team are also included in the team.

Under the leadership of ANM and Health Worker (Male) the working team and the consultative team will be constituted in each village. You will have to ensure that the health workers get both the teams work together in unison. Besides, conducting household surveys, they will also provide sexuality and gender counselling, motivate the community, distribute the condom etc. You will have to supervise the activities that will be carried out by the members of the team to strengthen the RCH Programme. The activities that they will perform are as follows:

- i. Assist in conducting household survey.
- ii. Ascertain children needing immunization.
- iii. Help in conducting immunization sessions/camps.
- iv. Identify pregnant mothers and bring them to sub-centre for ANC registration.
- v. Assist health worker (female) in identifying high-risk pregnant mothers
- vi. Inform any birth and death taken place in the area.
- vii. Report incidence of Diarrhoea, ARI or any other diseases.
- viii. Motivate eligible couples for accepting any family planning method.
- ix. Assist in organising women's group meetings.
- x. Distribute condoms & oral pills by acting as Depot holder.
- xi. Make arrangements for referral.

The above activities would provide scope for teamwork wherein each member contributes according to her/his potential. It needs a very congenial work climate. You as supervisor of 5-6 male health workers, have to inspire the team work spirit in them. As and when they come to PHC for procurement of vaccines, drugs, material, submission of reports, attending monthly meeting. You must demonstrate the cooperation among you and other members at PHC, you must extend support to workers to facilitate the works for which they have come to PHC. In order to make the team functional you should follow the steps given below:

#### **Steps for making your team functional**

- ◆ Identify activities, which can be done by each member of team.
- ◆ Consult them before assigning responsibilities.
- ◆ Assign activities with a time-frame.
- ◆ Monitor activities by asking them to inform progress.
- ◆ Give feed back to the team members on their performance.
- ◆ Give support and guidance to team members, wherever needed.
- ◆ Encourage the team members to continue with the activities assigned.
- ◆ Appreciate contribution of the team members.



To enhance the effectiveness of team, you as the supervisor and leader must perform the activities listed below:

- i. Educate all members of the team regarding information required for community needs assessment so that they gather this information for you.
- ii. Provide knowledge to all members of the team about the services under RCH programme, immunization schedule, and family planning methods.
- iii. Educate the team members about antenatal care, precautions to be taken for safe delivery, post-natal care, etc.
- iv. Provide technical assistance in identification of malnourished children, provision of supplementary nutrition and nutrition education to mothers.
- v. Share the information collected by the Male Health Worker through household survey or periodical home visits with other team members.
- vi. Consult the records of team members, and give them relevant feed back.
- vii. Supervise regular meetings with the village working team members for sharing information with each other.
- viii. Involve the team members in organising and holding community meeting and conducting IEC activities.

It is primarily your responsibility to ensure that the members of the team help each other so that team spirit is not only developed but also maintained and nourished in each member. Such team members cooperate and coordinate with each other's work and solve individual as well as group problems.

### **3.4 Organizing Meeting:**

Meetings provide an opportunity to team members to share experiences, learn from each other, extend their perspectives and solve problems jointly. As a supervisor you must ensure that the Health Workers conduct meetings of both the working team as well as consultative team. Besides, they should also organise separate

meetings with the working group and Mahila Swasthya Sangh, and patiently listen to their views as well as problems. You can use these forums to share with them the problems faced by you to get insight in rendering health care services and follow up services in a better manner. Try to attend these meetings held at subcentre level.

The working group members must be fully involved in organising meetings with the consultative group members. The Health Workers as key persons should decide the issues to be discussed in advance and fix the date, time and venue of such meetings and inform the members of consultative group through the working group members or while he is doing home visit. With the help of panchayat members resources may be sought for seating arrangement and serving of drinking water/tea/coffee etc. You must ensure that the Health Worker while conducting current meetings discusses all the points of the last meeting and actions taken in the follow-up. Each member should be given an opportunity to speak and express his or her views and listen to all others. You must ensure that all major decisions taken must be recorded in the minutes register.. Finally, at the end, he should always summarize all points raised and discussed and conclude the meeting with thanks to all the members.

#### **KEY POINTS**

- ◆ Ensure that a working team for each village falling in the area of all the sub-centres is constituted.
- ◆ Ensure that regular meetings with the working team are conducted, information is shared and feedback received.
- ◆ Assign responsibilities to each team member not only for collecting information but also for provision of services at doorsteps.
- ◆ Assign a health worker to follow up with each member of working team.
- ◆ Acknowledge the effort of each member, respect their contributions and provide help and guidance as and when needed.



## ***SUPERVISION AND ON-THE-JOB TRAINING***

### **LEARNING OBJECTIVES:**

With the help of this unit you should be able to:

- Identify the tasks to be performed by you as Health Assistant (Male)
- Provide supportive supervision to the health workers
- Identify the gaps in the performance of the health workers
- Apply your skills for On-the- job training.

### **CONTENTS:**

- Introduction
- Supportive Supervision
- Identification of gaps in performance of health workers
- On-the-job training

### **4.1 INTRODUCTION:**

Since every health centre is comprised of various categories of personnel such as health workers and helpers, acquiring their services, developing their skills, motivating them to high levels of performance and ensuring that they continue to maintain their commitment to the organisation are essential to achieving the health centre's objectives.

A large number of village health workers are contributing towards achievement of health objectives. Hence, as a supervisor of the sub-centres, you are also responsible for the performance of your staff and other village level workers such as Community Health Volunteers, Anganwadi workers and other Village level functionaries for cohesive programme performance.

## **4.2 SUPPORTIVE SUPERVISION**

For effective performance of health workers, supervision plays a crucial role. It is the process of constant observation, evaluation and providing guidance to workers. As a leader of the team of health workers at the sub-centres and community, supervision assumes great importance for you. It is the art of guiding, instructing and encouraging staff.

You are expected to provide guidance and support to the health workers in planning for the services, estimation of resource requirement for provision of these services, facilitate them to provide these services effectively and also identify if there is any shortfall or gap in the achievement of the objectives of these services. In order to enable the workers to provide the services in the expected manner, you have to give guidance in conducting each clinical procedure. These have been detailed out in Maternal Health and Child Health Blocks. Another important component of Supportive Supervision is sharing the workload of these workers being supervised by you.

### **As a supervisor of your team you must:**

- ◆ Constantly keep a track of your staff by giving them necessary directions.
- ◆ Help the health functionaries to solve problems.
- ◆ Counsel them whenever it is required.
- ◆ Constantly encourage them for their positive efforts.
- ◆ Measure their efficiency, results and impact of activities undertaken by the workers.



### **4.3 Objectives of Supervision:**

The main objectives of supervision are:

- To enable workers do their job skillfully/efficiently
- To develop subordinate's capacity to the optimal level.
- To motivate and maintain high morale in the team.
- To facilitate health workers in achieving their objectives.

### **Methods of Supervision**

Supervision can be done directly on the spot or indirectly through review of records/reports and opinions from other supervisors, other workers, beneficiaries, users of the services. On the spot, direct supervision is considered to be the best. Through this, gaps in the performance can be identified and immediate feedback given. Also, if needed guidance and support can be provided for doing the job correctly.

On-the-job supervision is considered to be the best, because supervision can identify shortcomings and immediately give guidance to the worker.

### **How to supervise?**

The activities comprising supervision can be divided into three stages. In order to make your supervision effective, you should follow the following stages

#### **Stage 1: Preparation**

Before supervision, you must prepare yourselves in the following manner:

- You must read documents e.g., CNA manual, RCH programme document, State Government rules and previous supervision reports of your workers, if available.

- You should identify priorities for supervision based on community health needs and services to be provided under the RCH programme
- You have to prepare a supervisory plan for providing supervision to all the workers under your jurisdiction/area.
- You should prepare a checklist for supervision, rating scales for assessment of performance etc.

## **Stage 2: Supervision**

During supervision:

- You should review service needs, workload etc. estimated by the worker based on CNA approach.
- You should cross-check the estimated services with district demographic calculation as given in Unit-I.
- You should ensure that proper records are maintained.
- You should check that the required supplies and equipments are available at sub-centre and in usable conditions.
- You should interact with the workers under your supervision.
- You should observe as workers carry out their tasks.
- You should review the Annual Action Plan and match it with the estimated service needs.
- You should interact with the other village level workers to discuss the activities conducted by them and the other health workers.
- You should interact with the beneficiaries and ask them their opinion regarding the services provided and received.
- You should identify gaps in the performance.
- You should identify gaps in the facilities/support required.

## **Stage 3: Follow up**

After supervision:

- You should carry out any follow up of support required
- You must clarify objectives and targets to be achieved under RCH.



- You should jointly organise with the MO, an on-the-job training programme
- You will have to modify your workplan as well as that of the worker as needed.
- Initiate action plan regarding supply/repair of equipments if needed.

#### 4.4 Supervisory Plan:

A Supervisory plan is nothing but a work plan for you to ensure that you are able to provide required guidance to all the workers as per their supervisory needs. In many states, you prepare an Advanced Tour Programme (ATP) for conducting field supervision. This is very similar to a supervisory plan. In a supervisory plan, you have to not only indicate about which sub-centre you plan to visit but also which services or activity you intend to supervise. A model is presented below. Make sure your supervisory work plan matches with the work plan of the respective health worker and your weekly work plan. The workers, who need more guidance may be given preference over others, and you should include more visits to that particular sub-centre in your plan.

#### MONTHLY SUPERVISORY PLAN

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
First	Sub-Centre A (Malaria outreach)	(Malaria outreach) at SC- B	Immun. at SC- A	Visit to Vill.2	Vill. 1 under SC- A Immun.	Meeting in Vill. 1 SC- A
Second	Sub-Centre B (Malaria outreach)	(Malaria outreach) at SC- D	Immun. at SC- B	Visit to Vill. 3	Vill. 4 under SC- B Immun.	Meeting in Vill. 3 SC- B
Third	Sub-Centre A (FP)	(Malaria outreach) at SC- C	Immun. at SC- C	Visit to Vill. 5	Vill. 3 under SC- C Immun.	Meeting in Vill. 4 SC- C
Fourth	Sub-Centre D (FP)	(Malaria outreach) at SC- A	Immun. at SC- D	Visit to Vill. 4	Vill. 5 under SC- D Immun.	Meeting in Vill. 2 SC- A

## 4.5 Supervisory Checklist as a tool

A checklist is a tool to help supervisors systematically monitor the health services being provided by health workers. It contains a detailed list of important steps for performing a particular task. It also helps you in identification of gaps in the performance. You may associate it with a rating scale by giving a score for each step. An illustrative example is given in Annexure no. 5.1

## 4.6 TRAINING:

As a supervisor of sub-centres, you must ensure that you have the right number and the right kind of people at the right places, at the right time, capable of effectively and efficiently completing those tasks that will help in achieving the health objectives. The most widely used method of training for improving task performance takes place on the job. On-the-Job Training places the health worker in an actual work situation and enables them to perform the task correctly and effectively.

A team of village level workers including the Health Workers (Male and Female), Anganwadi workers, trained dais etc. are involved in provision of services under RCH Programme at sub-centre level. As a supervisor of the sub-centre, you have to ensure that the training needs of the health workers in the sub-centres as well as the other village level workers like Traditional Birth Attendants (TBAs) and Anganwadi workers are met with.

**Training** is a learning experience in that it seeks a relatively permanent change in an individual that will improve his/her ability to perform on the job. We typically say training can involve the changing of skills, knowledge, attitudes and social behaviour.

Under RCH, greater emphasis has been laid on provision of quality of services. One of the ways to achieve this is to develop task performance competency through regular training. Therefore, as a supervisor of your area, you are responsible for training and development of your subordinates so as to improve the overall



quality of services. To carry out effective training, you must be able to determine the training needs of your subordinates based on identified gaps, which you are able to meet through on-the-job training.

#### **4.7 ON-THE-JOB TRAINING:**

The most widely used method of training for improving task performance takes place on the job.

On-the-Job Training places the health functionary in an actual work situation and enables them to perform the task correctly and effectively. The Supervisor is able to provide guidance at each step as required. In this process, you may have to demonstrate how to perform the skill correctly and ask the worker to observe. Then you must ask the worker to demonstrate the skill under your supervision. Repeat this till you are satisfied that the worker has learnt the skill.

Besides, Supportive Supervision and providing On-the-job training, you have to ensure involvement of other health functionaries by:

##### **a. Conducting Monthly Meetings**

You must conduct meetings of both the working team and the consultative team every month. Besides, you also have to organise separate meetings with the working group and patiently listen to their views as well as problems.

Meeting provides an ideal opportunity for face to face contact with different people, even opponents and provides a unique opportunity for interaction and resolving interpersonal conflicts.

Meeting is one of the most effective tools for management and administration of health activities. Communication during meetings needs to be persuasive and motivational. In some meetings, you have to act as a leader and in some others, you are only a participant.

**b. Developing other health related functionaries and Panchayat members for health action at community level**

Apart from managing the Health Centre staff, you must also ensure participation of Link persons, leaders of youth organisations, Panchayat members, teachers, women's group in health care delivery and guide them to assess community health needs.

The Working team mostly comprises of Health Workers (Female and Male), AWWs, TBAs and MSS and consultative group would comprise of Panchayat leaders, teachers, priests etc.

**c. Motivating Health Workers:**

A health worker gets motivated to do his job when he/she is acknowledged and appreciated for his/her effort made for providing adequate services as per needs of the community. This acknowledgement/appreciation works as a reward to him/her most of the times. You must demonstrate a sense of responsibility and commitment to your own job.

**How will you recognise a motivated worker?**

- Shows enthusiasm and has a positive attitude
- Believes his work is important
- Works well with his supervisor, health workers and other workers in villages
- Willingly takes part in planning, carrying out and evaluating his activities

As a supervisor follow these guidelines for motivating your workers:

**a. Set a good example**

You are a role model for the health workers working in the sub-centres. Maintain a positive attitude. Ask for help if you need it. If you make a mistake, admit it. Be punctual, regular



in your activities. These will encourage the worker to do the same.

**b. Develop and maintain good personal relations**

Be friendly and communicate openly. Try to understand the health workers behaviour, attitude etc. Do not criticise them unfairly, behind their backs, before other workers and clients. Maintain a good sense of humour and avoid getting angry.

**c. Use a participatory style**

Share information with health workers, so that they feel involved, and aware of what is going on around their sub-centre, PHC and higher up levels. Encourage feedback. Use participatory leadership style whenever possible particularly with the experienced good workers and accept good suggestions offered by the health workers.

**d. Guide, encourage and support health workers**

Giving guidance means working with health workers to help them perform their own task correctly. Let them know what you expect from them. Supporting them means providing the health workers a satisfactory work environment with equipments and supplies in working conditions and defending them in their dealings with the higher ups.

**e. Reward a good work**

Praise is a powerful motivator. Make your workers feel his/her efforts are meaningful and are appreciated. Hence, praise frequently and informally. Whenever a health worker does a good job, remember to praise before other workers, clients and medical officer, this will increase their self-confidence.

## ILLUSTRATIVE MONTHLY SUPERVISORY CHECKLIST FOR HEALTH WORKER (MALE)

NAME \_\_\_\_\_ SUB-CENTRE \_\_\_\_\_  
 PHC \_\_\_\_\_

ACTIVITIES	NOTES *		
	Date	Date	Date
<b>1. Team activities</b> (i) Participation in staff meetings (ii) Coordination with HW(F), HGs and Dais			
<b>2. Record keeping</b> (i) Prepare, maintain and use records and reports (ii) Maps and charts			
<b>3. Immunization</b> (i) Assist in immunization session (ii) Assist in school immunization. (iii) Educate community on immunization			
<b>4. Primary medical care</b> (i) Treatment of minor ailments (ii) Referral to PHC			
<b>5. Family welfare</b> (i) Motivating to eligible couples (ii) Distribution of			



<p>contraceptives</p> <p>(iii) Follow-up of acceptors</p> <p>(iv) Establish male depot holders</p> <p>(v) Promote family welfare services in the community</p> <p>(vi) Identify male leaders and help train them</p> <p>(vii) Attend community meetings to promote contraception</p> <p>6. <i>Nutrition</i></p> <p>(i) Identify malnutrition cases</p> <p>(ii) Distribute vitamins and mineral supplements</p> <p>(iii) Educate community on nutrition</p> <p>7. <i>Vital events</i></p> <p>(i) Record and report births and deaths</p> <p>8. <i>Malaria</i></p> <p>(i) Identify fever cases</p> <p>(ii) Taking of blood slides</p> <p>(iii) Treatment</p> <p>(iv) Referral</p> <p>(v) Educate community about malaria.</p> <p>9. <i>Communicable diseases</i></p> <p>(i) Identify and report notifiable diseases</p> <p>(ii) Preventive measures to control</p>			
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(iii) Educate community about communicable diseases			
10. <i>Environmental sanitation</i>			
(i) Chlorination of wells			
(ii) Waste disposal			
(iii) Latrine and soak pit construction, kitchen gardens			
(iv) Educate community about environmental sanitation.			
11. <i>MCH</i>			
(i) Identify and refer MCH cases to HW(F)			
(ii) Immunise pregnant women with TT			
(iii) Educate community about MCH services.			
12. <i>Sub-centre management</i>			
(i) Drugs and supplies			
(ii) Maintenance of equipment			
(iii) Logistics and communication			
(iv) Work planning and scheduling			
(v) Intersectoral coordination			
(vi) Community participation			

\* Number of columns depends on the number of beats made for supervision



### **KEY POINTS**

- ◆ You have to identify performance gaps in the workers under your supervision.
- ◆ You have to plan for your supervisory actions as per the needs of the health worker.
- ◆ You must provide guidance and support to the worker so as to enable him to perform the task effectively and efficiently.
- ◆ You must develop the competency of the workers through your supervision.
- ◆ You must use the checklist as a tool for conducting direct-on-the-spot supervision.





## ***MAINTENANCE OF RECORDS AND REPORTS***

### **LEARNING OBJECTIVES:**

With the help of this Unit, you should be able to:

- Explain the importance of records to be maintained and reports to be prepared at all the sub-centres.
- Describe the official records to be maintained and the reports to be submitted under RCH Programme at the sub-centre level.
- Explain the guidelines to be used for maintaining up-to-date records.
- Explain what is surveillance, why it is important and your role in surveillance procedure.
- Describe the information to be provided in monthly reports and prepare the reports in the formats prescribed under RCH programme.
- Use these reports in assessing your own performance

### **CONTENTS:**

Records	:	Definition
		Criteria of good records
		Importance of records
		Registers to be maintained
		Guidelines for maintaining these registers

Reports : Definition  
Monthly progress report  
Reporting formats

## **5.1 INTRODUCTION:**

This unit would help you understand the importance of maintenance of records and storage of information at sub-centres. Within the RCH programme, you are supposed to develop an Action Plan, set targets, estimate demands and assess performance of the health worker (male). In order to perform these activities you have to maintain accurate records. Accordingly, this unit provides guidelines for recording and storing information appropriately. A list of all the registers to be kept up-to-date is also given. This unit would also help you to develop skills in managing reports at sub-centres. Preparation of monthly reports in the format provided and prescribed by the Government of India would be explained. These reports are required to be submitted to PHC by the 15th of every next month. A copy of the format including the information to be supplied is also attached at the end of this unit.

## **5.2 RECORDS:**

Records are usually data or written information kept in daily diary, note-books, registers, cards etc. Records consist of information on work done, health status of the community members, in general, and also of individuals in particular. Records are also essential for administrative matters such as maintenance of accounts of supplies received and items used in rendering services in various sub-centre area.

Records should be:

- accurate
- accessible
- available when needed and contain information that is useful for assessment and making decisions regarding future actions.



Hence, records of different services provided need to be maintained at sub-centres. Though there is wide variation from State to State regarding the registers expected to be maintained at sub-centre, the registers listed below are essential for effective implementation of the RCH programme at the most peripheral level.

### **Registers needed to be maintained at Sub-centres**

- |     |  |   |
|-----|--|---|
| 1.  | Village records register   |   |
| 2.  | Household survey register  |   |
| 3.  | Eligible couple register   |   |
| 4.  | MCH register & immunization card   | - Maternal Care<br>- Birth<br>- New born & Child care |
| 5.  | Registers for recording contraceptives   |   |
|     | a. Condom distribution   |   |
|     | b. Oral pill register  |   |
|     | c. CU 'T'/IUD register   |   |
|     | d. Sterilization   | Male<br>Female  |
| 6.  | Sub-centre clinic register   |   |
| 7.  | Death register   |   |
| 8.  | Registers for recording meetings held for Consultative process                         |   |
| 9.  | Stock register   |   |
| 10. | Referral Register, and a duplicate copy of the monthly report submitted for each month |   |
| 11. | Daily diary  |   |

### **General guidelines for maintaining records at the sub-centres:**

**You as the health assistant (male) have to ensure that:**

1. Information is entered in the proper place(register/form) – for example, in the particular column in the appropriate register
2. Information is written down immediately as soon as possible and

is not deferred for some other time/day. Results are delayed in incomplete and inaccurate records, as one is likely to forget the event.

3. Records are brought up-to-date and avoid letting them piled up. Spend about half an hour at the end of your day so as to check that the records have been entered with all the information regarding that day's work.
4. Records should be entered clearly and neatly. It should be legible, otherwise it will be of no use either to you or to your supervisors.
5. Records are entered in order. Also ensure that all the registers are arranged either in alphabetical or numerical order (give a number to each register)
6. All the registers are kept in cupboard, dusted regularly and protected from cockroaches, rats and termites.
7. Do not let unauthorised person to read the records. These should be treated as confidential.
8. An adequate stock of stationary is maintained for the registers and all the forms needed to be filled and submitted.
9. All the old records (i.e. more than 5 years old) are destroyed.

### **5.2.1 Village records**

You have to ensure that the register is maintained to store the information regarding an overall picture of each village covered under the sub-centre area. This should record information on items listed below:

- Number of households ( a household is defined as consisting of those family members having a common kitchen)
- The population of each village



- The population distribution according to age and sex
- Number of Anganwadi centres with the name and address of AWWs.
- Number of private practitioners (Allopathic, Ayurvedic, Homeopathic, RMP etc.)
- Dais in each village (Name & Address)
- Schools – location
- Panchayat Bhawan – Name & Address of Sarpanch.
- M.S.S / Mahila Mandal members
- Voluntary organisation, if any
- Number of deep hand-pumps installed.

### **5.2.2 Household survey register**

You have to ensure that the information regarding each and every household is collected during household survey. After the initial survey, it should be revised every three years. The details of information, need to be collected and entered in this survey register have already been listed in Unit-I.

### **5.2.3 Eligible couple registers**

The Health Worker (Female) has to identify the number of couples where the wife's age is between 15-45 years from household survey register and must enter in this register with address. The family status with parity and age of the youngest child should be mentioned. The couple if using any contraceptive also needs to be recorded along with the details of contraceptive methods being used.

### **5.2.4 Maternal and child health register and contraception register**

The details of items of information that need to be recorded in these registers are discussed in maternal care and child care block.

### 5.2.5 Sub-centre clinic register

You must make sure that this register is maintained for keeping records of patients attending the sub-centre clinics. The attendance in antenatal, immunization, family planning clinics should not be recorded in this register.

The following columns are essential for this register:

S. No.	Date	Name & Address	Complaints	Medicines given	Remarks

### 5.2.6 Death register

You must ensure that the Health Worker (Male) enters all deaths occurring in the area covered by his sub-centre. The items of information to be recorded include:

- Date of death,
- Name & address,
- Age(years/months/days),
- Sex, and
- Cause of death.

### 5.2.7 Stock registers

Records of particulars related to all items provided and utilised at sub-centres should be maintained. The details of stock register are given in Unit-III.



### 5.2.8 Register for recording consultative process

You have to supervise the meetings with village working team constituted for each village and with other members of group of that village as has been discussed in Unit-I and Unit-II. You should ensure recording the details of each meeting in this register. The following information needs to be entered.

Month/ Year	Date & Time of holding the meeting	Venue/Place	Members attended	Items discussed

### 5.2.9 Referral register

The details of all referred cases should be entered in this register. This will also help you to undertake follow up of the referrals made.

Date	Name & Address	Age	Sex	Complaints	Reasons for referral	Referred to	Follow up actions taken
1	2	3	4	5	6	7	8

### **5.2.10 Daily Diary**

Each Health Assistant (Male) is expected to maintain a diary known as “Daily diary” in which he will record the daily activities performed in the field as well as at the clinic with regard to; immunization, antenatal check up and follow up, distribution of contraceptives, follow up of IUD and OP cases, identification of PID, RTI/STI cases, birth and deaths reported, malaria cases etc. The meetings conducted with the village working team and with the group of village representatives should also be mentioned in this diary.

This daily diary will enable the Health Assistant (Male) to update all the registers to be maintained and will also be helpful in preparation of monthly report. While visiting houses, he cannot carry all the registers but can always keep the daily diary easily which can be used for reference.

### **5.3 REPORTING:**

The performance or out-put of services rendered by the health worker (M&F) are reported in the formats prescribed to this effect. This information is communicated from the lowest to highest level of health services. These reports can be used as important management tools for assessment of quantity as well as quality of services provided at PHC and its sub-centre levels. These reports are also helpful for making decisions regarding future actions. You should be able to make out from this information whether you have been able to provide all the required services as planned or not. If not, then you should be able to find out the reasons for not being able to do these and then take action so that you can do it better in the next month.

With regard to RCH programme, you are supposed to ensure preparation of a monthly report at the completion of each month in the format provided by Government of India (Form-6) and submit it to MO (PHC) by 15th of the next month. In this format, there are five columns for entering information against each service. These include:



**i. Performance in corresponding month of last year**

Performance of that particular month which is being reported during the previous year should be entered in this column. e.g. If you are preparing the monthly report for June'99, then you should enter the total number of RTI/STI cases detected, registrations done during June'98 in this column against RTI/STI cases detected.

**ii. Performance in the reporting month**

How much is done in this particular month should be reported in this column. As per above example – you have to ensure that entry of the total number of RTI/STI cases detected in the month of June'99 is in this column.

**iii. Cumulative performance till corresponding month of last year**

As the year starts from the month of April every year, cumulative performance should be calculated from the month of April every year. Hence, in this report, you have to ensure that the health worker (female) enters total number of RTI/STI cases detected in the months of April, May and June in 1998 in this column.

**iv. Cumulative performance till current month**

Under your supervision the health workers have to enter the total number of registration done in the months of April, May and June of 1999 in this column.

**v. Planned performance in current year**

The total number of RTI/STI cases which the health workers have estimated through CNA and submitted in Annual Sub-centre action plan should be entered in this column.

The monthly report for the PHC also to be prepared and submitted (Form no.7). you can fill that form if asked by the MO(PHC) using the above mentioned guidelines.

You are advised to keep a duplicate copy of each monthly report submitted to PHC. You should ensure that filing of all these copies is done serially in a file so that these can be retrieved easily whenever needed for reference.

#### **5.4 RECORD KEEPING FOR DISEASE SURVEILLANCE**

Surveillance assumes great importance under RCH Programme. OPD registers provide important information to the health supervisors regarding various diseases under surveillance and also while visiting the community, he may come across certain disease patterns. Hence accurate record keeping is very essential. Surveillance can be of two types - active or passive. Passive surveillance is usually done by means of accurate record keeping.

*What is surveillance?*

**Surveillance** is defined as regular collection and analysis of prevalent mortality as well as morbidity pattern and other health related important events occurring in a given community setting as being reported by the peripheral health workers to higher authorities of health and family welfare department so that the decisions on 'Management of changes' occurring at community level could be taken in advance. However, such decision making would be possible only when the Health Workers report the events timely and with certain degree of accuracy.

The dictionary meaning of surveillance is 'close watching' on regular basis. Hence, it is not one time activity to be performed by you. Rather, it is a continuous process requiring your attention throughout the year and even year after year. The information coming to you in this regard by direct, indirect and even from discrete sources is important and you must report the same after preliminary verification.



You have to ensure that the Health Worker (M) along with the health worker (F) who are responsible for catering to the felt needs of health and family welfare services in an area of sub-centre regularly are aware of the mortality and morbidity patterns among all age groups of the community members. However, you are required to be more vigilant about the mortality and morbidity amongst mothers and children under five years of age who happen to be vulnerable group of our society. Generally, such information/data are collected as a part of the regular monthly reports by the health workers and submitted to the concerned MO PHC. Thus, this activity is already being performed by you and this is nothing but surveillance. However, in case of any incidence of AFP or any other vaccine preventable disease, you must inform the MO (PHC) immediately without any delay.

#### *Why surveillance is important?*

The basic aim of health services rendered through health personnel of various grades and skills is to reduce the sufferings of women and children by providing treatment so as to reduce the chances of mortality. It is, therefore, essential to examine the occurrence of diseases or death for introducing preventive measures whenever possible. The regular collection of number of cases of various conditions, diseases and deaths occurring out of those in the area of sub-centres under your PHC will enable you to check whether the mortality and morbidity pattern of such disease is increasing or decreasing over a period of time.

Similarly, detailed investigations on unusual number of deaths or occurrence of certain complaints/diseases can provide information on causes or the circumstances under which such events have occurred and thereby identify steps to be taken for preventing them in future.

Further, regular and complete reporting of the total number of deaths from a particular complaint/disease gives you a true picture about the size and magnitude of the problem.

### *Conditions/diseases expected to be reported*

Conditions/diseases against which specific activities (i.e. prevention and management) are undertaken under RCH programme include the following:

- a) Vaccine Preventable Diseases viz., Diphtheria, Pertussis, Tetanus, Whooping Cough, Poliomyelitis, Measles, Neonatal tetanus and childhood Tuberculosis
- b) Diarrhoeal diseases among children
- c) Acute Respiratory Infections/Pneumonia among children,
- d) Maternal Deaths, Deaths among children under five years,
- e) Reproductive Tract Infections among women etc.
- f) Acute Flaccid Paralysis (AFP) – Routine and immediate reporting.

### **Sources of information on diseases and deaths:**

This information can be collected/compiled from the sources mentioned below:

1. Clinic records/Clinic Registers: As mentioned earlier, the Health Workers have to maintain a clinic register (i.e. OPD register) for the clinics conducted. Cases of diseases, mentioned above, when reporting at sub-centre clinic, you must ensure that their name, age, sex and the diagnosis is entered in the clinic register. At the end of the month, these cases can be counted and reported to you or the PHC.
2. Information from community: You must ensure that the health workers also get information on these conditions directly during the course of home visit. They must record such events in their daily diary and report the same at the end of the month or even earlier depending upon urgency of the matter.



You can also ensure that the Health Worker (Male) obtain information on such events from identified informants in the community like Community Health Volunteers, Village Health Guides or village leaders whom Health Worker (Male) can specifically orient for this purpose. You can also during your supervisory visits obtain information on relevant issues.

There are a few important points in the process of supervising the Health Workers that you should remember about identifying and recording of diseases and deaths:

Firstly, it is important to identify these events are recorded correctly. For this, simple definitions of these common conditions have been worked out (refer to child health and maternal health blocks).

Secondly, you have to ensure that double counting is avoided: if a child makes two visits to the clinic for the same episode of disease count it as one case only.

Thirdly, you must make sure that only those cases are counted, which are confirmed. Count the cases reported by the informants separately and report them only after the Health Workers have confirmed the condition as per the definition already provided.

Fourthly, a specific time frame needs to be kept for reporting e.g., One week/two weeks. Ensure that the cases occurring and reported during this period are only counted and those cases are not included that occurred outside this time frame.

**Remember that correct, complete and regular reporting of events mentioned above is extremely important for understanding the true situation in the community and to help higher authorities to initiate appropriate corrective actions, non-reporting, under-reporting and over reporting of events can lead to either wrong actions or no action on the part of the authorities. This may affect the health situation in a community adversely.**

### KEY POINTS

- ◆ Ensure that all records are kept accurately, are accessible and available when needed.
- ◆ Make sure that all registers should be maintained up-to-date
- ◆ Use information recorded in registers for assessment of quantity as well as quality of services provided and also for preparation of future action plan
- ◆ Ensure preparation of monthly report in the format prescribed by the 15<sup>th</sup> of the next month and keep a duplicate copy of the same at sub-centre.

### Registration of Births and Deaths:

Reliable estimation of population, births, deaths and other vital events in the community is an important component in planning the health service delivery at community level. This helps us to assess the impact of various interventions of the RCH package and also estimating the service needs at various levels. It is, therefore, important that data collected and compiled by the civil registration system is used effectively (which contain data on all the vital events including births, still births and deaths etc.) on a continuous basis. In the system, in most of the States the notifiers include health functionaries, who would be using this data for their planning of day-to-day work. In the recently held conference of Chief Registrars of Births and Deaths, a 100 % registration of vital events would be achieved by December 1999. The following formats are to be filled on receiving information of any live birth, still birth and death in your own area. The different forms are as follows:



**FORM NO 2**  
**LIVE BIRTH REPORT**

Serial No. \_\_\_\_\_

Registration Unit/Village/Taluq/Tehsil/Block/Thana/Distt  
\_\_\_\_\_

Town/Municipality \_\_\_\_\_

1. Date of Birth
2. Sex Male/Female
3. Name of Child
4. Place of birth
5. Permanent residential address
6. Father's
  - i) Name
  - ii) Literacy
  - iii) Occupation
  - iv) Religion
7. Mother's
  - i) Name
  - ii) Literacy
  - iii) Occupation
  - iv) Religion
8. Age of mother in completed years at confinement
9. Order of birth  
(Number of live births including the birth registered)
10. Type of attention at delivery
11. Informant's
  - i) Name
  - ii) Address

Date .....

Signature or left thumb mark of the informant

### FORM NO. 3

#### STILL BIRTH REPORT

Serial No .....

Registration Unit/Village/Taluq/Tehsil/Block/Thana/Distt

---

Town/Municipality \_\_\_\_\_

1. Date of Birth
2. Sex Male/Female
3. Place of birth\*
4. Permanent residential address
5. Father's
  - i) Name
  - ii) Literacy
  - iii) Occupation
  - iv) Religion
6. Mother's
  - i) Name
  - ii) Literacy
  - iii) Occupation
  - iv) Religion
7. Age of mother in completed years at confinement
8. Type of attention at delivery+
9. Informant's
  - i) Name
  - ii) Address

Date..... Signature or left thumb mark of the informant

---

\* If the delivery took place in hospital or any other institution, write "hospital" or "institution" giving its name, otherwise give full address of the place of birth.

+ If the delivery was conducted in a hospital or maternity home, write the name of institution otherwise mention whether it was conducted by a qualified or unqualified midwife and give her name.



**NOTE:**

1. In the case of illegitimate birth the word "illegitimate" should be entered in the remarks column and no person's name should be entered as that of the father, unless there is a joint request of the mother and the person acknowledging himself to be father of the child.
2. In the case of multiple births make separate entry for each and a reference in the remarks.
3. If the person is a non-worker insert the word "Nil" in the column for occupation.

**FORM NO 4  
DEATH REPORT**

Serial No .....

Registration Unit/Village/Taluq/Tehsil/Block/Thana/Distt

---

Town/Municipality \_\_\_\_\_

1. Date of death
2. Full name of the deceased
3. Place of death
4. Name of the father/husband
5. Age
6. Sex: male/female
7. Marital status
8. Occupation
9. Religion
10. Nationality
11. Permanent residential address +
12. \* Cause of death
13. Whether medically certified (Yes/No)
14. Kind of medical attention received, if any
15. Informant's:
  - i) Name
  - ii) Address

Date.....      Signature or left thumb mark of the informant

---

+ The address of the parent, in the case of a child, husband/late husband in the case of married women/widow and deceased if independent, is to be given in this column.

\* Where the cause of death is medically certified the cause marked (-) in the medical certificate form no. 8/8A is to be entered here.



**NOTE:**

1. If the deceased was over one year of age, give age in completed years. If the deceased was under one year of age give age in completed months and if below one month give age in completed number of days and if below one day in hours.
  2. If the person is a non-worker, insert the word. 'Nil' in the column for occupation.
-

(To be submitted by the 15<sup>th</sup> of the following month to PHC)

**FORM 6**

**MONTHLY REPORT FOR SUB-CENTRE/URBAN HEALTH POST/REVAMPING CENTRE  
(REPORT OF ANM/MPW (MALE))**

General Information

1. State: \_\_\_\_\_
2. District: \_\_\_\_\_
3. PHC : \_\_\_\_\_
4. Sub-centre: \_\_\_\_\_
5. Population of PHC: \_\_\_\_\_
6. Population of Sub-centre: \_\_\_\_\_
7. Reporting for the month of : \_\_\_\_\_
8. Eligible Couples (as on 1<sup>st</sup> April of the year): \_\_\_\_\_

S.N.	Services	Performance in corresponding month of last year	Performance in the reporting month	Cumulative performance till corresponding month of last year	Cumulative performance till current month	Planned performance in current year
<b>1.</b>	<b>Ante-Natal Care</b>					
<b>1.1</b>	Ante-natal cases Registered					
	a) Total					
	b) Less than 12 weeks					
<b>1.2</b>	<b>No. of pregnant women who had 3 check-ups</b>					
<b>1.3</b>	<b>Total no. of high risk pregnant women referred</b>					
<b>1.4</b>	No. of TT doses					
	a) TT 1					
	b) TT 2					
	c) Booster					
<b>1.5</b>	<b>No. of pregnant women under treatment for anaemia</b>					
<b>1.6</b>	<b>No. of pregnant women given prophylaxis for anaemia</b>					
<b>2.</b>	<b>Natal Care</b>					
<b>2.1</b>	Total No. of deliveries					



S.N.	Services	Performance in corresponding month of last year	Performance in the reporting month	Cumulative performance till corresponding month of last year	Cumulative performance till current month	Planned performance in current year
2.2	Home deliveries a) (I) by ANM (ii) by LHV b) By trained birth attendant c) Untrained birth attendant					
2.3	Deliveries at sub-centre					
2.4	Complicated deliveries referred to PHC/FRU					
3.	<b>Maternal Deaths</b>					
3.1	During pregnancy					
3.2	During delivery					
3.3	Within 5 weeks of delivery					
4.	<b>Post-Natal Care</b>					
4.1	No. of women given 3 post-natal check-ups					
4.2	Complications referred to PHC/FRU					
5.	<b>RTI/STI</b>					

S.N.	Services	Performance in corresponding month of last year	Performance in the reporting month	Cumulative performance till corresponding month of last year	Cumulative performance till current month	Planned performance in current year
5.1	<b>Cases</b> a) Detected b) Treated c) Referred					
6.	<b>Pregnancy Outcome</b>					
6.1	a) Live births b) Still births	M	M	M	F	F
6.2	Order of Birth in 3.1 (a) a) 1 <sup>st</sup> b) 2 <sup>nd</sup> c) 3 <sup>rd</sup>					
6.3	Newborn status at birth a) Less than 2.5 kgs b) 2.5 kgs or more c) No. of high-risk newborns referred to PHC/FRU					

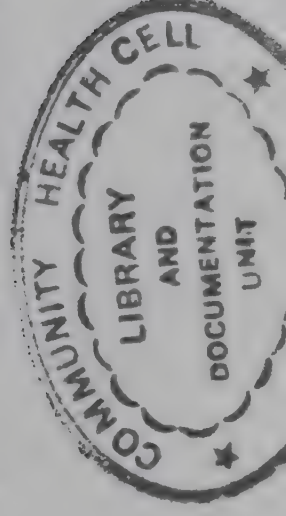
S.N.	Services	Performance in corresponding month of last year		Performance in the reporting month		Cumulative performance till corresponding month of last year		Cumulative performance till current month		Planned performance in current year	
		M	F	M	F	M	F	M	F	M	F
7	Immunization										
7.1	Infant 0 to 1 year BCG DPT1 DPT2 DPT3 OPV0 OPV1 OPV2 OPV3 Measles										
7.2	Children more than 18 months DPT booster OPV booster										
7.3	Children more than 5 years DT										



S.N.	Services	Performance in corresponding month of last year		Performance in the reporting month		Cumulative performance till corresponding month of last year		Cumulative performance till current month		Planned performance in current year	
		M	F	M	F	M	F	M	F	M	F
7.4	Children more than 10 years TT										
7.5	Children more than 16 years TT										
7.6	Adverse reaction reported after immunization										
8.	Vitamin A administration (9 months to 3 years)										
	Dose 1										
	Dose 2										
	Dose 3- 5										

S.N.	Services	Performance in corresponding month of last year		Performance in the reporting month		Cumulative performance till corresponding month of last year		Cumulative performance till current month		Planned performance in current year	
			F	M	F		F	M	F		F
9	Childhood Diseases										
9.1	<b>Vaccine preventable diseases</b> a) Diphtheria i) Cases detected ii) Treated iii) Referred iv) Deaths b) Poliomyelitis (AFP) i) Cases detected ii) Treated iii) Referred iv) Deaths										

S.N.	Services	Performance in corresponding month of last year		Performance in the reporting month		Cumulative performance till corresponding month of last year		Cumulative performance till current month		Planned performance in current year	
		M	F	M	F	M	F	M	F	M	F
9.2	c) Neo Natal Tetanus i) Cases detected ii) Treated iii) Referred iv) Deaths d) Measles i) Cases detected ii) Treated iii) Referred iv) Deaths										
9.3	ARI under 5 years (Pneumonia) a) Treated with Cotrimoxazole b) Referred to PHC/FRU c) Deaths										
9.4	Acute diarrhoeal diseases under 5 years a) Treated with ORS b) Referred to PHC/FRU c) Deaths										



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S.N.	Services	Performance in corresponding month of last year	Performance in the reporting month	Cumulative performance till corresponding month of last year	Cumulative performance till current month	Planned performance in current year
10.	<b>Child Deaths</b>					
	a) Within 1 week					
	b) 1 week to 1 month					
	c) 1 month to 1 year					
	d) 1 year to 5 years					
11	<b>Contraceptive Service</b>					
11.1	Eligible couples contacted					
11.2	Male sterilisation					
	a) Total no. of cases motivated					
	b) No. of cases followed up					
11.3	Female sterilisation					
	a) Total no. of cases motivated					
	b) No. of cases followed up					

S.N.	Services	Performance in corresponding month of last year	Performance in the reporting month	Cumulative performance till corresponding month of last year	Cumulative performance till current month	Planned performance in current year
11.4	Total IUD insertions a) Cases followed up b) Complication c) Discontinued i) Removed ii) Expelled					
11.5	Total Oral Pill users a) Old users b) New users c) Complications d) Discontinued					
11.6	Total condom users					
12	Abortions a) No. of women referred for MTP b) No. of MTP done c) Cases followed up d) Complications e) Deaths					

Sl.No.	Services	Performance in corresponding month of last year	Performance in the reporting month	Cumulative performance till corresponding month of last year	Cumulative performance till current month	Planned performance in current year
<b>13</b>	<b>Communicable Diseases</b>					
13.1	Malaria a) No. of fever cases identified b) No. of blood smear slides sent to PHC c) No. of fever cases given presumptive treatment d) No. of positive cases of malaria e) No. of positive cases given radical treatment f) No. of anti-mosquito activities co-ordinated g) No. of high-risk villages identified					
13.2	Tuberculosis a) No. of suspected cases i) Identified ii) Referred b) No. of sputum positive cases c) No. of TB cases followed up					



#### IV Interaction with Community

Serial No.	Meeting with	No. of Meetings
1.	Panchayat Health Committee	
2.	Mahila Swasthya Sangh	
3.	Anganwadi Workers	

## v Monthly Stock Position

Sl. No.	Item	Opening Balance	Received	Total	Consumption	Balance	Requirement
1.	IFA Large						
2.	IFA Small						
3.	Vitamin A						
4.	Cotrimoxazole						
5.	ORS packets						
6.	Methylergometrine						
7.	Chloropheniramine						
8.	Paracetamol						
9.	Anti-spasmodic tablets						
10.	Inj. Methylergometrine						
11.	Mebendazole						
12.	Syringes & Needles						
13.	Vaccine day carrier						
14.	Steriliser Autoclave						
15.	Chloramphenicol						
16.	Centrimide Power						
17.	Povidone ointment 5%						
18.	Cotton bandage						
19.	Contraceptives a) Nirodh b) Oral Pills c) IUDs						
20.	Disposable Delivery Kit						
21.	Chloroquine Tab						

### VACCINE RECEIVED FROM PHC

S.N	Name of vaccine weekly session 1 Date/Dose	Vaccine received for weekly session 2 Date/Dose	Vaccine received for weekly session 3 Date/Dose	Vaccine received for weekly session 4 Date/Dose	Vaccine received for weekly	Vaccine received	Total
1.	DPT						
2.	OPV						
3.	DT						
4.	TT						
5.	BCG						
6.	Measles						

Last training attended (mention month and year)

Date of inspection made in reporting month by

- (i) MPW (Male)
- (ii) MPW (Female/ANM)

LHV \_\_\_\_\_  
MO (PHC) \_\_\_\_\_  
BEE \_\_\_\_\_  
DMO \_\_\_\_\_

A note on the progress made as well as the handicap or achievement experienced in the field either because of shortage of essential supplies, vaccines or personnel essential to the programme and resistance encountered on account of social and cultural beliefs.

(Do not use more than this space)

Signature ANM  
Signature (Male Health Worker)





# Communication

for

*Health Assistant (Male)*







## *Introduction*

**F**or many years now, you have been working as a Male Health Assistant supervising the health services provided by the grassroot level health workers. The services provided so far were essentially target-oriented and consisted of limited health services. With the launch of the RCH Programme, the services provided to the people have acquired a wider definition by becoming target free. The services now are client-oriented and should be supported by conducting the needs assessment approach at the community level.

Communication has become an indispensable element in the health services. With increased level of knowledge and understanding in people, it is important that people are given relevant and adequate information which will help them to take vital decisions regarding their health and family welfare. It is believed that communication can bring an empowerment of the people, which can help them to decide their health needs.

The knowledge of communication will help you to understand your environment and take timely decisions and adequate measures. Further, as a communicator you will be able to provide guidance to your health workers to meet the special needs of special groups. The purpose of this module is to help you to acquire various communication skills, which are crucial to being a good supervisor and trainer.

Let's turn the page and take a look at the module.



## UNIT I

### ***YOUR ROLE IN PROMOTING RCH PROGRAMME***

#### **SUB-UNITS**

- **YOUR NEW ROLE**
- **UNDERSTANDING THE ROLE OF COMMUNICATION IN BEHAVIOUR CHANGE**

#### **INTRODUCTION**

**A**s a Male Health Supervisor, your role is that of an intermediary health functionary. It is an extremely important role, since you are a link between the male health worker (Multi Purpose Workers, male) at the sub-centre and the medical officer at the PHC. So far your role was mainly for control of TB, Malaria, etc., besides participating in Child Immunization Camp and to help ANM in general. Under the new RCH Programme, your responsibility is extended to supervise and guide the male health worker on providing quality client-oriented RCH and other health services.

As a Male Health Supervisor, you are a very important part of the Health and Family Welfare machinery. You are a supervisor and most important link between the grassroot level health workers and the higher administration. Consequently to help realise a behaviour

change, you will need to guide the health workers to meet their required objectives.

The health and family welfare services now have become more defined and objective in approach. Apart from the health services, your male health workers would also be required to provide a 'communication treatment' to their clients to bring about a change in the health behaviour of the people. This change in behaviour requires efforts on your part. In Sub-Unit-I, explains you why behaviour change is important and how communication can be of help in the process of changing people's behaviour. Sub-Unit-II, explains the stages, factors and indicators of behaviour change.

The ultimate goal of communication efforts put in by you and your health workers is to ensure that people in comfort adopt positive health behaviour (practices). The new RCH Programme directs its basic thrust on behaviour change where communication plays a very important role. In Sub-Unit-I, you will understand the need for a behaviour change and how communication can be used for behaviour change. Sub-Unit-II, deals with the stages of behaviour change and the important indicators of behaviour change.



### **LEARNING OBJECTIVES**

After going through this unit, you should be able to :

- ✱ Explain your new role under the RCH Programme in relation to communication.
- ✱ Discuss the process of communication which helps in changing behaviour and promoting healthy life-style.



## **Sub-Unit I : Your New Role**

### **★ Content Areas**

- ◆ The New Focus
- ◆ The Emphasis on Communication
- ◆ Your Role as a Communicator

## **Sub-Unit II : Understanding the Role of Communication in Behaviour Change**

### **★ Content Areas**

- ◆ Understanding Behaviour Change
- ◆ Need for Behaviour Change
- ◆ Using Communication for Behaviour Change

### **KEY POINTS**

### **TEST QUESTIONS**



## SUB UNIT - I

### YOUR NEW ROLE

#### The New Focus

The Health and Family Welfare Programme has witnessed number of changes from 1952 onwards. Today, the programme has been more sharply defined in the form of the Reproductive and Child Health Programme (RCH).

The following are the directions in which changes have been brought under the new RCH Programme:

ISSUE	OLD PROGRAMME	NEW RCH PROGRAMME
Primary Goal	Promote two child family	Encourage smaller families but help the clients to meet their own health and family planning goals.
Priority Services	Family Planning	Full Range of Reproductive and
Sterilisation	Immunisation	Child Health Services
Performance	Number of Cases	Quality of Care, Client Satisfaction, Coverage
Management Approach	Top-Down Target Driven	Decentralised Driven by Client needs
Attitude to Client	Motivate Persuade	Gender sensitive, listen, assess needs, inform, advise
Accountability	To the Government System	To the client and the community
Training of Workers	Vertical Duplication Overlap	Integrated No Duplication or overlap

Moving the Family Welfare Programme towards a client-oriented reproductive health approach has major implications for

communicating and working with communities, your team workers and the clients. The reproductive health package has implications for a whole range of communication activities that are broader in scope than before.

### **The Emphasis on Communication**

The RCH Programme has brought the role of communication to the forefront. Communication is now seen as an important tool which can be skilfully used by the health workers and supervisors..

To increase the access to the services, the thrust on the involvement of private practitioners and the support to NGOs for the implementation and innovation are new aspects of the RCH Programme. All this requires that communication be placed central to all other activities. The programme provides for empowering people to help them make responsible decisions. In this effort, use of communication knowledge and skills can be of great significance.

As a supervisor, you are a person in helping people to seek the health services according to their needs. Using various communication skills, you can supervise and monitor the health workers and help them to bring in an effective change in the health behaviour and practices of the people. Simply put you should keep communication as an important part of your activities since communication allows for more active participation and freedom of choice among the clients. Communication in the RCH Programme has three vital elements of information, education and communication.

### **Your Role as a Communicator**

You must be aware of your role as a supervisor of the health workers. Whatever you undertake requires that you be a good communicator. However, you should be able to effectively communicate with your health workers from time to time and motivate



them to use communication with care along with their role as a health provider.

Being a good communicator is very important to be a good leader. With good communication skills, you can lead your health workers to perform effectively and meet the requirements of the clients. As a communicator, you should also be able to teach communication skills to the health workers working under you.

Information, Education and Communication are important parts of the big sphere of communication. It now includes a much wider health and family welfare package that are broader in scope than before, besides, your other supervisory functions relating to TB, Malaria, immunization and management of child diseases.

Apart from your supervisory skills, the position you occupy is a very important one since you are a link between the grassroot level male health workers, ANM and the block level health functionaries. You act as a link between the health workers and the medical officers at PHC.

In your position as the supervisor of health workers, communication is your most important tool. You will need communication in a variety of situations. Some situations where you will need to use communication are:

- You want to motivate and inspire the male health workers effectively to perform their tasks.
- You want to inform and give feedback to the medical officer at the PHC regarding the immunization programme.
- Rumours affect the belief in a particular programme. Here you can use communication to get feedback from the village panchayats, school teachers and almost anyone who are able to give the facts. You can also help the health workers to get rid of these rumours by using their communication skills (Please refer to the ANM Module on Communication).

- A newly married man has come to you and wants to get answers to certain personal questions, which he is unable to reveal to anyone else.
- You have noticed that some villages within your PHC area are very poor in practicing family planning. So you have to visit the village and interact with the opinion leaders, school teachers, religious leaders etc.



## **SUB UNIT - II**

### **UNDERSTANDING THE ROLE OF COMMUNICATION FOR BEHAVIOUR CHANGE**

#### **Understanding Behaviour Change**

Human behaviour varies from person to person. It is as varied as one can imagine. Depending on a number of factors, the health behaviour in people are positive (washing of hands, etc.) or negative (chewing tobacco, pan, etc.). Change in the lifestyle of the people will require that there is a change at the mental level. And to bring about this change in the mindset or pattern of activity, the health professionals will need to change the behaviour of the masses and make them aware of the health and family welfare benefits. By changing the behaviour, we can facilitate the process by which the people will willingly come and seek the health benefits. This is known as a 'positive health seeking behaviour', which is of importance now.

#### **Need for Behaviour Change**

It has been widely agreed that a change in behaviour can bring about a whole new approach to the health services. People will no longer wait for the health system for health and family welfare services but would themselves seek it. This will end the age-old process of dependency on the health workers and the health system and will subsequently allow greater freedom and choice. Behaviour change is needed for very many reasons. They vary from person to person and from place to place. Some notable reasons for seeking a behaviour change are:

- It can help form a positive health practice in which the people willingly seek the health and family welfare benefits.



- Behaviour change is essential to help the people (both men and women) to participate equally in the decision-making related to number of children, age of marriage of the children etc.
- Behaviour change will help the men to change their attitudes and treat women equally in the decisions of their life related to the family.
- A change in behaviour will help the male members of families to realise the need for lesser number of children. Consequently, they will practice birth control and limit the size of the family.

### **Using Communication for Behaviour Change**

#### **♦ Using communication for a change in health behaviour**

To bring about a change in the health behaviour, you will have to put in a lot of effort. This effort is possible only when communication is used with care and sensitivity.

The people whom you want to serve have different beliefs, knowledge and understanding. And to convince these diverse groups is an enormous task. It is not possible for the health workers to educate and motivate people belonging to diverse groups one by one to bring in a change in their behaviour. This is simply impossible. A change in the behaviour of people will only occur when there is a change in the social values, customs and education of the people.

As a supervisor, your role in this entire process will be to supervise, monitor and provide active support in the communication activities of the health workers. You should ensure that the health workers carry out the important communication activities with care.

As you must have seen, communication is the process in which people exchange ideas, facts, feelings or impressions. The purpose of communication in your case as a health professional is simply to bring

about a behaviour change. To put it in simple words behaviour change will occur when the client gets appropriate information that satisfies his doubts, remove misconceptions and fulfil other requirements. He then remains for such change. If this is backed by quality service, he not only gets inclined but in most cases acts on the change.

To keep the health workers, the clients and the community motivated, you need to communicate with them frequently. This communication has some purposes. It is needed for:

- Informing, educating and motivating mothers, couples and adolescents for a behaviour change for appropriate health practice.
- Motivating male health workers to bring about a change for healthy behaviour in his clients.
- Co-ordinating the efforts of the partners like the panchayats, school teachers, religious leaders and anganwadi workers to bring about a positive health behaviour amongst the people.

To bring about a change in the health behaviour, the communication provided by your team should :

- Inform
- Motivate
- Educate and
- Be sustained over a longer period of time



### **KEY POINTS**

- Behaviour change for positive health seeking behaviours.
- Communication for behaviour change.
- Physical, biological, socio-economic, psychological factors help forming behaviour.
- Behaviour indicators essential for behaviour change.
- Change in attitude leads to behaviour change.

### **TEST QUESTIONS**

- Why is behaviour change needed?
- Why is communication important for behaviour change?
- What are the stages towards a behaviour change?
- What are the factors that are important for forming behaviours?
- Describe the various important behaviour indicators which are required for behaviour change.





## UNIT II

### *INTERPERSONAL COMMUNICATION SKILLS*

#### **SUB-UNITS**

- ➔ **LEARNING THE IMPORTANCE OF IPC**
- ➔ **COMPONENTS OF IPC AND THEIR USES**

#### **INTRODUCTION**

Interpersonal Communication is an effective tool to bring about a change in the health behaviour of people and in motivating workers and team members. In your work situations, you mostly use interpersonal communication to interact with your health workers, the medical officers, the clients visiting the sub-centre, and with opinion leaders, panchayats, school teachers and others. Proper understanding of interpersonal communication helps you to effectively supervise the work performance of your health workers. Sub-unit I explains the meaning, importance and the situations where interpersonal communication can be effectively used by you.

For making your interaction effective you will require to acquire certain specific skills. Sub-unit II explains the IPC skills

which can help you in your work and win the confidence and trust of your workers as well as of the community members.



## **LEARNING OBJECTIVES**

After going through this unit, you should be able to:

- ✱ Discuss the importance of different interpersonal communication skills in improving the reach and quality of RCH services.
- ✱ Describe different IPC skills like verbal and non-verbal and active listening.
- ✱ Use IPC skills to help your health workers to improve their services.
- ✱ Demonstrate the use of IPC skills in performing different activities.

## **SUB-UNIT I - LEARNING THE IMPORTANCE OF IPC**

### ✱ *Content Areas*

- Importance of Interpersonal Communication
- Using Interpersonal Communication - Where and How

## **SUB-UNIT II - COMPONENTS OF IPC**

### ✱ *Content Areas*

- Non-Verbal Communication
- Example of Non-Verbal Communication
- Becoming an Effective Speaker
- To be an Active Listener

## **KEY POINTS**

## **TEST QUESTIONS**



## SUB UNIT - I

### IMPORTANCE OF INTERPERSONAL COMMUNICATION (IPC)

Interpersonal communication (IPC) is an essential part of our daily life. We communicate when we talk to people living around us. In your position as a Male Health Supervisor, IPC would mean the sharing of ideas, information and experiences with different sets of people you deal with in your daily work at the PHC or during your visits to the village. Simply defined, IPC means face to face sharing of information and feelings with the following persons:

#### ♦ Communication with an individual or a couple:

- (a) One-to-one basis - This communication takes place when you talk to a health worker, the medical officer or when you meet a client at the Block PHC.
- (b) One-to-two basis - This type of communication takes place when you talk to two persons at a time. When you talk to a couple or any other two persons, you are performing a 'one-to-two' communication.

#### ♦ Communication with a small group:

When you meet a small group of people, who belong to the Panchayat, youth groups, self-help groups, etc., this meeting is called small group communication. The meeting at the PHC which are chaired by the medical officer or the informal meetings that you hold with all the male multi purpose workers (MPW), under the PHC are also examples of 'small group communication' in which you need to learn about IPC and using the skills for better performance.

Let us start from your own experience to explain further about interpersonal communication. Can you remember how often you speak with the health worker, the medical officer or clients whom you



keep on meeting from time to time? Definitely you talk to one person or two at a time or to a group of people taken together from time to time during the course of the day as a daily work schedule. This direct communication between you and others is known as interpersonal communication (IPC). IPC includes verbal, non-verbal and listening skills. By understanding and practising these IPC skills, you will be able to explain and motivate the health workers to become an able and effective worker. Maintaining a closer relation with your health worker is important for the success of the RCH Programme.

IPC will also help you to share your knowledge with the medical officer, husbands, and male adolescents who visit your PHC or whom you have come to meet during your field visits in a sub-centre area. This direct interaction helps you in the following manner:

- It helps your health workers to get answers to their problems directly from you, without any delay.
- It helps you to give direct feedback to the medical officer from time to time.
- It is a personal form of communication and can enable a male to express their feelings effectively face to face to you without fear or feeling embarrassed when they visit a PHC.
- It helps you to effectively initiate behaviour change by starting a dialogue with your clients at the PHC and with the Male Health Workers to provide quality services to those who need it most.

### **WHERE TO USE INTERPERSONAL COMMUNICATION**

There are many occasions where you can use your IPC skills from time to time. You can use IPC skills for:

At the organisation level:

- ▲ Solving the queries of male health workers.
- ▲ Motivating health workers to effectively perform their activities.
- ▲ For briefing your PHC Medical Officer about field situations.
- ▲ For training your team members, multi-purpose workers (male) of Sub-Centers.

At the PHC or community level:

- ▲ Educating adolescent boys about problems they face during puberty.
- ▲ Helping people to accept immunisation for their children.
- ▲ Mobilising panchayats to co-operate with you in your health activities, including control of Malaria, TB, HIV/AIDS etc.
- ▲ Taking history of a patient.
- ▲ Counselling your male clients to help them take decisions.
- ▲ Forming partnerships with community groups.

## IPC Skills

As you develop, understand and practice IPC skills, you can effectively supervise the male health workers and also become an effective communicator yourself. Moreover, a good understanding of IPC skills can also help you to teach the health workers as to how to use IPC skills while interacting with their clients or partners. Let us examine some important IPC skills beginning first with non-verbal skills.







## SUB UNIT - II

### USING NON-VERBAL COMMUNICATION

Effective communication consists of verbal as well as non-verbal skills. For example, if you use friendly, polite words but maintain a rigid body posture, the health worker or your client is likely to think that you are indifferent or insincere to him. Non-verbal communication include your body posture, gestures (made by the hands or movements of the head), expressions of your face and the movement of your eyes, tone of your voice. Let us take a look at the non-verbal skills that are required for effective communication.

- **Touching with your hands** — Touching is closely related with emotions and it shows deep feelings, which cannot be expressed by words alone. If you place your hand on your health worker's shoulder or a client (male) who has come to PHC you will find his response positively. This simple touch gives an impression to the health worker that you appreciate his work or his problem. It gives them confidence and enthuses them to be more vigorous.
- **Movement of the eyes** — Eyes send powerful messages between people in a face to face meeting. You must have noticed that even before you start speaking to someone, you develop an eye contact. A direct eye contact creates trust. Eye contact shows whether the health worker is paying attention to what you are saying or not. Eye contact can also be used to control your conversation. Your eyes can reveal whether you have understood the message from your health worker or your client and also whether you want more information from him.

Following are some common eye movements, which give different messages without saying a word!

<b>EYE MOVEMENT</b>	<b>MEANING</b>
• Wide open eyes	→ Surprise
• Avoiding eye contact	→ Shying away
• Blinking the eyes frequently	→ Fear/weakness/ submission
• Looking constantly	→ Hostile/impolite

- ▲ **Expressions of the face** – *Face is the index of the mind.* Facial expressions send powerful messages while talking. For example, if you give a blank expression on your face, it may mean that you are not interested to listen to the person with whom you are talking. On the other hand, a pleasant expression on your face, may mean that you are eager to help.

Smiles also convey meaning. If you give a simple smile, it means that you are happy. Again a broad smile can mean that you are willing to communicate willingly.

- ▲ **Gestures and movement of head and hands** – Did you ever notice the hand movements that you make while talking? Gestures are an important part of the verbal communication. In reality, they help in making the words that you speak more powerful. When you have to tell the health workers about how to explain about ORS preparation to the parents of child, you can use your hands to indicate the measurement of salt and sugar. This will make it easier to remember things for the health workers and there will be no room for any doubt or misunderstanding. Following are some common gestures which convey negative meaning:

<b>HAND GESTURES</b>	<b>WHAT THEY MEAN</b>
<ul style="list-style-type: none"> <li>• Playing with a matchstick</li> <li>• Folding the fist</li> </ul>	Signs of restless mind or even disagreement or boredom.



The movement of the head tells others about what you are feeling. Following are some very common head movements and their meaning:

<i><b>HEAD MOVEMENT</b></i>	<i><b>WHAT THEY MEAN</b></i>
• Nodding the head	→ Agreeing
• Turning away the head	→ Not interested
• Moving the head sideways	→ Refusing
• Bowing the head	→ Depression or feeling ashamed

- ▲ **Posture and body movement** – Body posture also conveys feelings (positive or negative). When you are explaining the health worker on how to counter rumours and misconceptions, you should maintain a posture and body movement showing positive feelings, like leaning towards the health worker in a friendly way. A negative posture or body movement like leaning back in the chair shows your disinterest and makes the health worker take everything very lightly.

<i><b>BODY POSTURE</b></i>	<i><b>WHAT THEY MEAN</b></i>
• Sitting erect	→ You are serious about the talk
• Sitting loosely	→ You are careless and disinterested
• Bending towards	→ You show that you care
• Leaning back in the chair	→ You are not interested to talk

- ▲ **The dress that you wear** – As a supervisor, the dress you wear is also important. Dresses reveal your personality. When you meet a panchayat member or a man who needs your help, you can prefer to wear a dress that is the usual dress code of the area where you are working. A good dress can help others form a favourable impression about you.



## **BECOMING AN EFFECTIVE SPEAKER**

### **Speaking is important for you:**

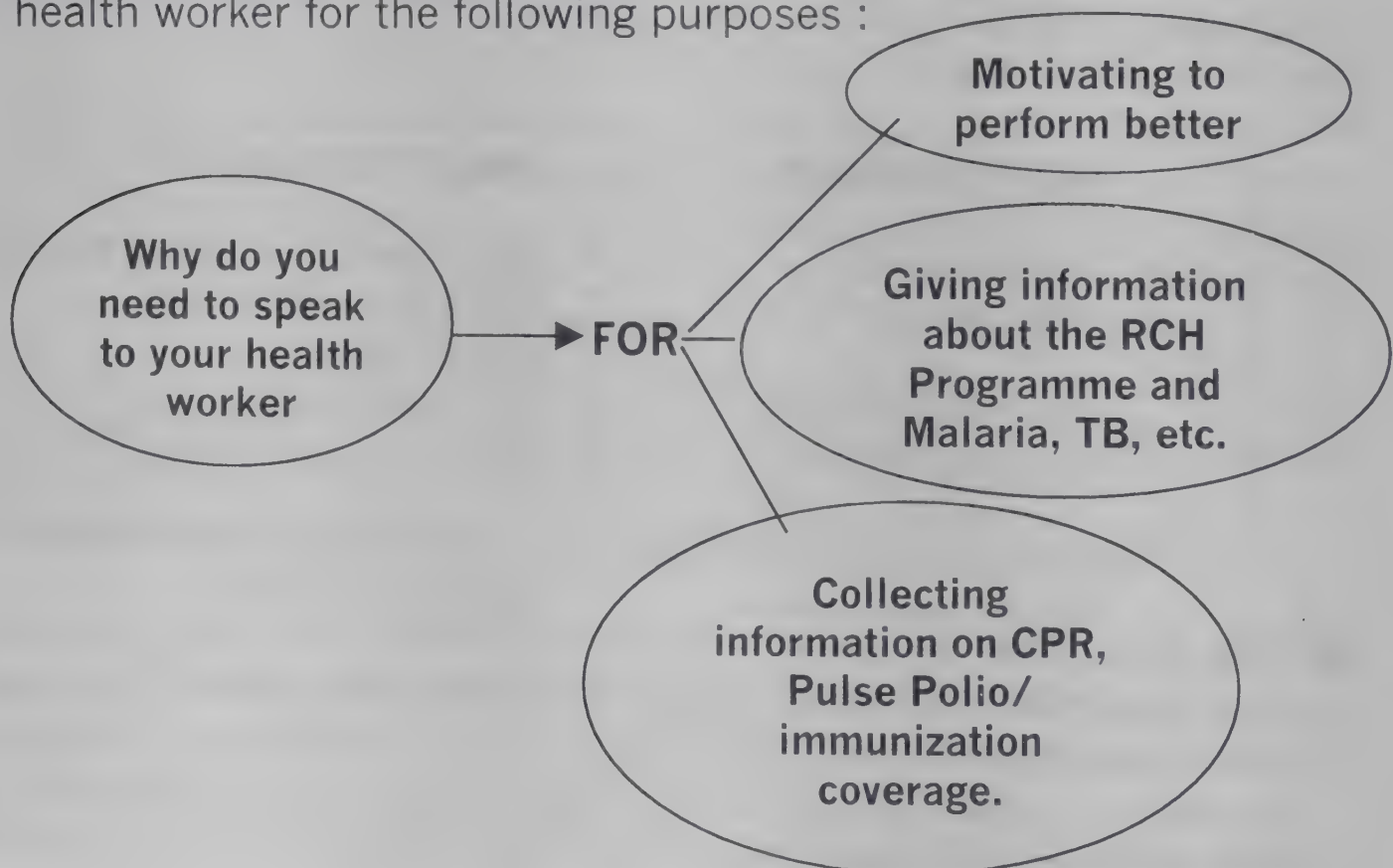
Effective speaking is an important element of any communication. All social relationships and goodwill depends on good communication. As a Supervisor, you should ensure that your health workers remain interested in what you say to them. But how can you sustain their interest? Simply, you can follow the following points which will help you to become a very effective speaker.

### **HOW TO BECOME AN EFFECTIVE SPEAKER?**

To become an effective speaker, you will need to be clear about the following:

#### **1. Why do you need to speak to your health worker?**

As a Supervisor, you should be able to identify the purpose of speaking to the health worker. Identifying the purpose will help you to frame the contents and words better. You may need to speak to the health worker for the following purposes :



Apart from health workers, you will also need to speak to your colleagues and supervisors during the meetings at the PHC, with the village panchayats or with clients who visit the PHC or during the monthly review meetings at the PHC. Here you need to seek and give information on your/other's activities.

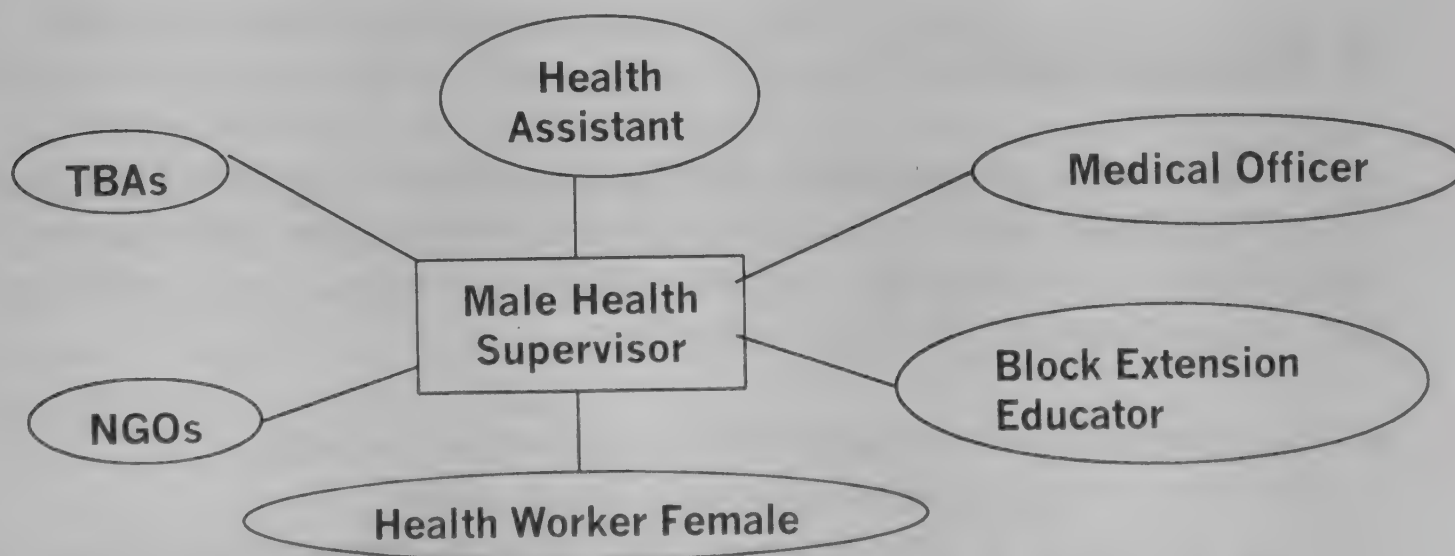
## 2. What is to be spoken?

Before you begin, you can decide on:

- What facts your information should include?
- Whether your information requires examples?
- What are the points on which you would need to emphasis?
- What message should be repeated?
- What points you will use to summarise ?

## 3. Whom are you speaking to?

The ways in which you speak to people will differ with different listeners. You should decide the tone of your voice, the subject matter and the language according to the persons with whom you are speaking to. Your audience can be :



*The people you should communicate with*

#### 4. When to speak?

The situation and time also influences your speech. Different situation and time can influence the way you speak to your colleagues/health workers or the clients. To make your speech effective, you need to either decide the timings which make it suitable for you to be an effective speaker or be aware of the situation when you are speaking to your clients. Following situations may be there:

- You are speaking to a health worker who is facing resistance from his clients.
- Speaking to a husband (who has five children) about sterilisations in the presence of other men.
- Speaking to a group of health workers who have not been able to motivate couples for contraceptive use/sterilisation in their sub-centre area at a time when it is late for them to go back to their homes.
- Speaking to a helpful panchayat member who is interested in the immunisation programme in his village but is involved in local politics.
- Speaking to an arrogant school teacher who does not want health education in his school.

#### 5. How you speak?

The way you speak to the health workers or the client is also very important. You have to speak in a different tone and manner with the different persons, like health workers, couples, male, adolescents etc. It is important to decide whether:

- You are using visual aids like a chart while speaking.
- You are using gestures and body movements.
- You are using a simple language. And avoiding the technical and difficult words which can make it difficult to understand.
- You are repeating important information.
- You can address a person/or a group in a personalised tone.
- You are summarising important issues/ideas at the end.



## Using Non-Verbal Language:

**You simply need to follow some basic non-verbal communication rules, which apply here also:**

- Be careful about the posture of your body. It is better if you relax by taking one or two deep breaths before you start speaking.
- Be careful of the hand gestures that you make. You should remember that your hands are 'talking for you'. Make your gestures to mean something and do not threaten people with them.
- Keep an eye on all aspects of your voice. Your tone, volume and pitch should be according to the theme of your conversation. Generally, the more relaxed you are, the more effective your voice will be.

When you are speaking to your clients, it is always better if you can include specific information in your speech. A detailed information will raise the confidence of your health workers and they will be always willing to listen to you. Effective speaking skills also requires that you have an understanding of the attitudes, feelings and needs of your listener. A good speaking skill can build the confidence of your clients and do a lot of good. An in-effective speech reduces the confidence of the people in the health provider.

### **TO BE AN ACTIVE LISTENER**

While you attend to your duties as a Supervisor, you interact with various kinds of people, like the health worker, community members and your own team members like the medical officer. In the course of your interactions, you exchange views, inform, counsel,

conduct interviews, attend meetings, etc. While doing these activities, you should be able to use active listening skills. If you listen attentively or with concentration, you will be able to understand or comprehend what is being said by your clients or health workers.

### **What are the Advantages of Active Listening?**

If you listen to the speaker actively, you can improve your supervisory skills:

- Understand what is being said by the health worker.
- Retain in your memory what the problems are.
- Develop a mind that can concentrate and understand important information.
- Take the right decisions which conforms to the needs of health worker.
- Win the trust of the health worker.

### **If you do not listen actively, you may:**

- Misunderstand what is being said by your health worker.
- Hardly remember what was said.
- Develop a mind that will fail to concentrate on and understand important information.
- Effect your work efficiency as a Supervisor.
- Not be able to win the trust of your Health Worker.

#### **✓ Some Golden Rules on Active Listening**

- Do not let your mind wander. Focus on what your workers are saying and what they want to convey.
- It is better to take mental notes of what is being said. This will help you to decide what actions need to be taken.
- Do not close your ears to different views other than yours.
- Do not have any preconceived notions about your workers.

## How to Become an Active Listener?

As a grassroot level Health Supervisor, you should understand why active listening is very important. Active listening helps you to understand your staff/clients which will help you to supervise/serve them better. The process of active listening can be described in the following five steps:

- ▴ **Paying attention to verbal and non-verbal messages** – While listening to the health worker or your client, pay attention to his verbal and non-verbal messages. Note whether your client is maintaining an eye contact or smiling. Note whether his tone is sweet or harsh.
- ▴ **Understanding what your client is saying** – Understand the message that your health worker is giving and find out about his problems. Your understanding of his problems will make it easier for you to find solutions, which will be acceptable to them.
- ▴ **How to remember what you have heard?** – You can remember what you have heard if you go step-by-step in giving your attention to:
  - The problem raised by the health worker;
  - His needs from you; and
  - What he says about his/her own capacities to solve the problem.
- ▴ **How to evaluate the information that you have received?** – As a listener you should not '*take in information through one ear and allow it to go out through the other*'. You need to clearly understand the meanings of the information that you have received and evaluate its importance. This will also help you to decide the actions that you need to take.
- ▴ **How to understand your client's needs?** – After evaluating the messages of the health worker, you will need to decide whether:
  - Health Worker/client needs counselling;



- Health Worker needs simple information;
- He needs motivation; or
- He needs encouragement.

In establishing a rapport and building a relationship with your health worker and the community, Interpersonal Communication will help you in the key programme areas of the programme. These skills can give you a rich dividend when you have to work with other health providers. Using IPC skills with the health team can help in solving the problems. This way, IPC can help you in winning the support and cooperation of all members for delivery of quality services.



## KEY POINTS

- IPC is sharing of information and feelings.
- IPC is important for solving client's problems.
- IPC is to help, motivate and educate clients.
- Non-verbal communication is body posture, gestures, expression of the face, movement of eyes and movement of the head.
- Touching and direct eye contact creates trust.
- Two-way communication is better than one-way communication.
- Effective speaking is key to motivating resistant clients.
- Active listening is essential for understanding clients better.

## QUESTIONS

- ✧ Why is IPC important for you?
- ✧ What are different IPC skills and where can you use them?
- ✧ What are the components of non-verbal communication?
- ✧ Why is direct eye contact with your clients essential?
- ✧ Is two-way communication better than one-way communication?
- ✧ What is effective speaking?
- ✧ What is active listening?







## UNIT III

### ***INTERVIEWING, COUNSELLING, AND HANDLING MISCONCEPTIONS AND RUMOURS***

#### **SUB-UNITS**

- **LEARNING HOW TO INTERVIEW**
- **COUNSELLING TECHNIQUES AND SKILLS**
- **HOW TO HANDLE RUMOURS & MISCONCEPTIONS**

#### **INTRODUCTION**

**W**hen you meet the health worker, or your clients, during your visit to the sub-centre you seek crucial information from them about the programme activities like immunization, safe deliveries, contraceptive use and other such activities.. The method that you use for seeking this information is known as an interview. Sub-Unit I tells you about the various techniques and skills that are required for a good interview. By learning more about the problems of the community, you can use the counselling skills to help the people find the best possible solutions to their individual or group/community problems. Sub-Unit II explains the concept of counselling and show you the way to become a good counsellor and interviewer so that you are able to use them for serving the community better.

At times, however, you may find that inspite of their best efforts the health workers are not able to bring any change in their clients behaviour. This happens because the people refuse to give up their faith in old values and beliefs and your health worker cannot provide such answers to their arguments which can satisfy them. Moreover, there are occasions when some negative news about the health services spreads. These negative news are called rumours. Sub-Unit III gives you an insight into these rumours and misconceptions. This unit also talks of the techniques that your health workers can use to deal with them.



### **LEARNING OBJECTIVES**

After going through this unit, you should be able to:

- ✱ Describe the importance of an interview in seeking information from clients and health workers.
- ✱ Demonstrate skills of interviewing.
- ✱ List-out different techniques and skills for effective counselling.
- ✱ Discuss the importance of managing different rumours and misconceptions in your area.

### **SUB-UNIT I : LEARNING HOW TO INTERVIEW**

#### **★ CONTENT AREAS**

- ◆ Importance of an Interview
- ◆ Questions for an Interview
- ◆ Using right Techniques for an Interview
- ◆ Interviewing Skills

## **SUB-UNIT II : COUNSELLING SKILLS**

### **★ CONTENT AREAS**

- ◆ Importance of Counselling
- ◆ Counselling Techniques
- ◆ Skills required for Counselling
- ◆ Do's and Don'ts of Counselling

## **SUB-UNIT III : MANAGING RUMOURS AND MISCONCEPTIONS**

### **★ CONTENT AREAS**

- ◆ What are Rumours and Misconceptions?
- ◆ How to Diagnose and Handle Rumours and Misconceptions?
- ◆ Types of Rumours and Misconceptions.
- ◆ Using IPC Skills Effectively to Convince and Motivate People.

### **KEY POINTS**

### **TEST QUESTIONS**



## **SUB UNIT - I**

### **IMPORTANCE OF AN INTERVIEW**

#### **◆ What is an interview?**

Interview is a form of interpersonal communication where the motive is to seek information. In an interview, you ask questions and seek their answers from the clients, TBA, HW, etc. These answers



become like signpost on the road as they help you to get a clear idea about the problem you are facing. It helps you to understand the problems that your health worker is facing in the field as well as helps you to assess the kind of services that are most needed in the block.

### ♦ **When to do an interview?**

Interviews are done in situations where you want to obtain more information relating to a specific issue or overall situation at the block level. Let's look at some specific situations where interviewing can help you in your efforts to gather information.

- You want to learn the details of a particular problem being faced by a health worker (HW) in his sub-centre area. For example in a village people of that area start developing a negative attitude towards immunisation. Consequently no one in the village will listen to the health worker and bring their children for immunisation.
- You want to learn the problems of an adolescent boy who is unable to share his problems and has come to talk to you at the PHC regarding some of his physical and mental problems relating to **sexuality**.
- You want to discuss the rumours and misconceptions that prevail in a village with the village sarpanch.
- You may want to gather information from your health workers about the problem being faced in conducting immunisation.
- You are helping the HW in conducting a meeting with community leaders or supervising the community needs assessment survey and you go to the community members for seeking information.

## QUESTIONS FOR AN INTERVIEW

### TYPES OF QUESTIONS

Before you conduct an interview, it is important to know the kind of questions that you should ask. There are two types of questions. They are **open-ended** and **close-ended questions**.

**Close-ended questions** are simple and specific. The answer is short in a word or two. For example, the question :- "How many members are there in your family ?" etc. **Open-ended questions** are long and give a detailed answer. For example, the question :- "What problems you have faced in the immunisation programme? ".

Before you actually conduct an interview, it is important to see how 'open-ended' and 'close-ended' questions bring out the complete or incomplete answer.

**While interviewing your clients, Health Workers, Community Partners or Community Leaders, you will need to keep the following points in mind:**

- **Close-ended questions should be used only to get specific information.**
- **The open-ended questions should be used to seek a more elaborate information.**
- **For a good interview, close-ended questions should be followed by open-ended questions. Interviews with 'only close-ended' or 'only open-ended' questions should be avoided.**
- **Incomplete answers are like a story without an end!**



## **USING TECHNIQUES FOR AN INTERVIEW**

In your position as a Male Health Supervisor, you will need to supervise and monitor the health activities spread over an entire block. You will need to gather information from your clients, health workers, and the community partners. Moreover, during supervision, you should be able to guide your health workers and teach him the techniques of interviewing when he is unable to seek relevant information from the person/client. All this requires that you should be an expert in interviewing.

Following are the techniques that can guide you in conducting an interview :

### **↳ Understanding the problem**

You should be clear about the problem or issue on which you need to conduct an interview. This will help you to pose questions that are appropriate in seeking the desired information from your client. The issues or problems can be different for different people.

The people you need to interview can be:

- a health worker working in your Block area;
- a village sarpanch who is a partner in an immunisation programme;
- a mother who is having a baby for the first time and is confused about her symptoms;
- a couple who have come to learn about spacing or sterilisation; and
- an adolescent girl who is anxious about the physical changes in her body.



### └ Focussing on your objective

After identifying the issue or the problem, you should try to understand the objective for the interview. If the interview is simply to gain feedback, it will contain simple questions. If it is meant to bring about a bigger change in the behaviour or in the way a health worker needs to change her programme activities then the interview is to be conducted in a more detailed manner.

### └ Asking relevant questions

During the interview, you should ask only those questions which are important and which can help you meet your objectives. It is good to ask personal questions at the beginning of the interview. This is called a 'warming up' and it helps the person whom you are interviewing, to relax. Thereafter you should ask the important questions, which will give you the information you are seeking.

### └ Interviewing Time

The time taken for interviewing is also very important. Too long an interview should be avoided. Keep it as long as it sustains the interest of the interviewee.

### └ Choosing a suitable place

The environment also plays an important role in interviewing. For example if a health worker is interviewing a client in a dirty sub-centre, the client may feel uneasy and may cut-short the interview. A clean and tidy sub-centre will make the client sit for a longer period of time.

### └ Giving time to answer

Enough time should be given to the person you are interviewing. A successful interview wants that clients are relaxed and have adequate time to think and present his/her reply.

### ➤ **Avoiding frequent interruptions**

Frequent interruptions should be avoided in an interview. Interruptions break the flow of the interview and upsets the mood of the person being interviewed. So it is better if you allow the person to answer without creating hurdles of interruptions.

### ➤ **Using simple language**

Often your client or community members do not follow the technical and special phrases that are used during an interview. So care should be taken to avoid technical terminology. Use simple words and your aim should be that your questions are understood. Only then you will get relevant information.

### ➤ **Taking down notes**

Sometimes, it is possible that you may be required to take a number of interviews - of health workers or clients. And as a human being it is impossible for you to remember the details of all the interviews. So it is always better if you take down some notes of the interviews, which will allow you to remember the details later on.

## **SKILLS REQUIRED FOR INTERVIEWING**

Apart from the techniques of interviewing, you will also need to develop some skills that will help you to become a good interviewer. These IPC skills are given in detail in Unit I and so we will discuss them in brief here. Following are the skills that you will require for interviewing:

### ➤ **Verbal skills**

Your support to your clients is like a banyan tree, which gives shade to the travellers from the scorching sun. The way you speak is very important. You should use a proper volume, pitch

and tone when asking questions during an interview. If you are loud and have a harsh tone this will either scare your clients or put them off! Your questions will only get 'readymade answers' and not the 'real answers'.

### └ Listening completely

As a health worker, you should have the patience to listen to what your client says. Listening to your client's problem will help the client to trust you and answer your questions better. Here you can make use of the active listening skills that you have learnt in Unit 1. Active listening can help you to select important points from the information your health worker has given you.

### └ Non-verbal language

Non-verbal communication is also important for a successful interview. While interviewing you should be able to use gestures with care and also understand what your client is conveying through his body language. How successful you are at interviewing, depends on how effectively you use the non-verbal language. The attitude and emotions that you display also help clients to give complete answers and become positive towards you.

Finally, it must be clear to you that interviewing is a special form of communication which can help you to serve your clients better. Interviews have a lot of uses but you will find that as a health worker its most important use lies in **counselling** your clients.







## SUB UNIT - II

### IMPORTANCE OF COUNSELLING

#### What is counselling ?

Counselling is an important part of a health worker's job. As a supervisor, you may also sometimes be required to counsel clients who visit the PHC. Counselling is different from motivation or education. It is much more than that. **M**otivation helps in influencing the client with examples and evidence to help them make a particular decision. And **E**ducation simply means giving health information, which will enable the clients to gain knowledge to help them improve their health practices. **C**ounselling consists of motivation, education and much more. **C**ounselling is a process which can help the client to:

- Understand his feelings about the problem.
- Seek information and gain knowledge.
- Make his own decisions to solve the problem in the best possible way.

#### To be a good counsellor, you need to:

- ⌋ Become a friend to your health worker.
- ⌋ Be a good listener, listen to health worker/client.
- ⌋ Be helpful by offering advice.
- ⌋ Have a good knowledge about the work.
- ⌋ Give correct and complete information.
- ⌋ Give the facts.
- ⌋ Be a good communicator — use non-verbal and verbal skills effectively.
- ⌋ Keep in constant touch with your client.
- ⌋ Motivate the client.
- ⌋ Build self-esteem of the client.
- ⌋ Avoid any biases against the health worker/client.
- ⌋ Ensure your health worker /client can solve her/his problem(s).

**Counselling can be useful in the following situations:**

- **With couples or with man who need counselling about different kinds of contraceptions:**

- About different kinds of contraceptions and their advantages and disadvantages.
- About sterilisation and also for removing the misconceptions about it.

- **With the families (husbands) of the pregnant women who are at risk:**

- About the precautions to be taken.
- On making them aware of the risks that are involved.
- Advising them about the need for regular check-ups.
- About the steps to be taken in case of an emergency.

- **With adolescents**

- About the biological differences between a male and female and the problems of growing up.
- Advising about pre-marital and unprotected sex.
- About the right age for marriage and raising a family.

- **With parents for child care:**

- About any problems or refusal for immunisation.
- About the need for a proper nutritional diet.
- On the importance of breast-feeding.
- On infant illnesses and their precautions.
- Dependence on quack.

- **With health workers facing difficult clients:**

- Non-compliance of spacing methods by couples.
- Overbearing clients and their family.
- 'Demanding' parents who want MPW (male) to visit home anytime. and medicines to be provided for all ailments.
- Community members who are disrespectful.

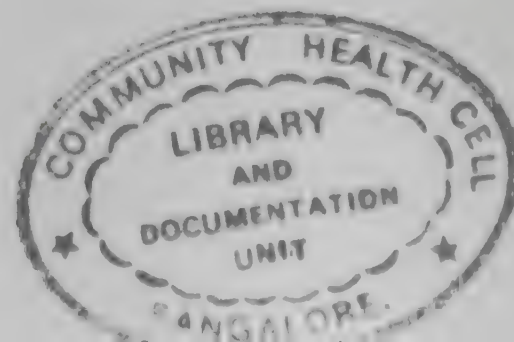


## **COUNSELLING TECHNIQUES**

Every counselling is a unique experience. This is because every client is different from the other. This must be understood that as a supervisor of health workers you may have to counsel them if someone has problems in coping with his situation and work. (Most of the time we use the word 'client' in these units but you can replace it with a 'health worker' as well"). Every health worker/client has a different problem and need a different solution. This makes the counselling process very interesting because you keep on meeting different people with different problems. Again counselling is not meeting the client/health worker just once. It means building a relationship, during which the client – a man – experiences confidence in you to begin with, discusses his problems with you and goes through the process of finding solutions. This cannot be possible in just one meeting. The counsellor has to ensure that your health worker/client comes for regular visits. Given here are seven steps which will make it easier for you to understand the process of counselling:

### **SEVEN STEPS TO COUNSELLING:**

- **Focus your attention:** As you begin the counselling session, you need to focus all your attention on your client.
- **Show acceptance:** Accept the views your client expresses. As a counsellor you should not show your client, your own prejudices and interrupt the client. If the counsellor stop the client with his own remarks at this point, your client may not disclose any of his problems and the counselling session may end there abruptly.
- **Show empathy:** Empathy is not sympathy. Having empathy means that the counsellor is able to identify himself with the situation of the client's. This identification will help the counsellor in understanding the patient's problems better or have a more empathetic attitude towards the health worker.



- **Do probing:** Sometimes the client may miss out some information or feel embarrassed or shy to share it with the counsellor. The counsellor can extract this information by asking probing questions. Probing will give the counsellor more information that the client was not willing to offer earlier. Probing is necessary to understand the problem better. The counsellor can take the help of open-ended questions that have been discussed earlier in this Unit.

**Probing is required for:**

- Understand the circumstances and also the decisions that the client is planning to take.
  - Help those patients who are shy to reveal their problem easily.
- **Advising:** After probing is done, the counsellor will be in a position to understand the patient's problem. This understanding can help the counsellor to plan the best possible solution to the problem with her patient. The counsellor can also use some examples to help him understand different options available to him to solve his problems.
- **Paraphrasing:** Paraphrasing helps you to be on the same mental wave length as your patient. In paraphrasing you simply repeat what your patient says. This will make her feel that you have understood her completely. While paraphrasing, you should clarify any doubt or wrong impressions.
- **Summarising:** This is the last step in a counselling session. Here the counsellor should list out the main points of the discussion towards the end of the session. This is necessary to help your patient as well as the counsellor to remember the outcomes of the discussion in a nutshell. Summarising will guide the counsellor in understanding the main issues which require solutions.

We will try to illustrate these techniques through an example:

**Shamlal** is an experienced Male Health Supervisor of a PHC. He is hard working, and his performance has been upto the mark.



But he has not visited the Ramnagar sub-centre for quite sometime now. *Ranjan* is a male health worker at the sub-centre. He is 26 years old and has joined the sub-centre a year ago. He is well-read and a keen worker.

***Ranjan :*** Can I come in ?

*Shamlal looks up and sees Ranjan 'the male health worker' standing uncertainly at the door of the PHC.*

***Shamlal :*** *(smiles and greets his client): Namaste Ranjan.. Yes! of course you can come in. But would you mind waiting for a few minutes. I'll just finish my work of keeping away these files and papers so that we can talk without interruption.*

All the while, as Shamlal spoke to Ranjan, the tone of voice was friendly and relaxed. While speaking itself he had walked up to his client and gently urged him towards a wooden bench.

Although Ranjan sat on the bench, Shamlal noticed that he did not relax. He seemed tired and edgy. Shamlal decided to postpone his cleaning plans and sat down beside Ranjan. Outside, it was early morning, and a gentle breeze was blowing. The surroundings were favourable towards conducting a counselling session.

***Ranjan:*** *You haven't come to the sub-centre for a long time. I had hoped you would come and guide me sometimes.*

***Shamlal:*** *I know. I'm sorry for not being there earlier. I know you must have been very disappointed? Was there anything special that you wanted to speak about? I'm here now, so you can tell me why you wanted to see me.*

While Shamlal, the Male Health Supervisor was speaking, he maintained his eye contact with his health worker. He focussed his eye on Ranjan and gently shifted his gaze from time to time to make him feel relaxed.



Occasionally, Shamlal moved his gaze away from his health worker, so that Ranjan did not get the uncomfortable feeling of being stared at. He faced him squarely, leaning slightly forward to communicate that he was interested in listening to what Ranjan had to say. Shamlal also casually reached out his hand and placed it on Ranjan's thin arms, gently squeezing it to convey the feeling of reassurance. All the while he maintained **his expression** to indicate his interest and encouragement. Gradually Ranjan began to relax. He even managed to give a weak smile to Shamlal.

**Ranjan :** *I'am feeling very nervous about working in these village. People are unknown to me. I find doing the rounds of households very inconvenient.*

Shamlal had already observed that Ranjan looked pale and he remembered that Ranjan was uncommunicative during the monthly meetings. He knew that Ranjan had previously refused help because of that, he had not made any helpful contacts. Shamlal did not want his own suggestions thrust on Ranjan. He wanted his health worker to assess his own condition as serious enough to reach out for help.

**Shamlal :** *You want to be shifted from this sub-centre ?*

**Ranjan :** *I don't know. Some people here are nice but most of them are strangers and they are not coming to the sub-centre.*

**Shamlal (empathising) :** *Yes, I can see that you are very worried.*

Even though Shamlal knew Ranjan desperately needed support and guidance, he restrained **himself** and with the help of verbal prompts allowed his client to express his feelings. Ranjan reached out and clasped **Shamlal's** hand tightly and said: "I need you to suggest me how to organise my daily routine and get introduced to opinion leaders!"

Shamlal gave Ranjan a broad smile and assured him that he would give all the help he could. In the course of the conversation, Ranjan accepted that he needed some tips on organising immunisation sessions. Shamlal then explained to Ranjan that he

would require the help of MSS members for which he must attend and organise the village meeting immediately. Shamlal explained that Ranjan should take the help of ANM and Anganwadi Worker. He had given adequate information as a first step towards the solution of his problem. They decided to meet again soon.



### **SKILLS REQUIRED FOR COUNSELLING**

To be a good counsellor, certain skills need to be developed. As the health worker works in the field and practice counselling, he becomes a good counsellor with experience. He needs to make an effort to show understanding, empathy and patience towards the client, who is totally dependent on him for help, support and encouragement. The example of Shamlal, the Male Health Supervisor and Ranjan, a male health worker has been given to explain you how the different techniques of counselling can help you in dealing with the specific needs of the clients as well. Let's now learn about the skills that a counsellor needs to practise to become a Perfect Counsellor!

- **Good Interviewing Skills** - A counsellor should have good interviewing skills. The kinds of questions to be asked to the clients are given in the sub-unit I on Interviewing.
- **Eye Contact** – It is said '*eyes are the mirror of the heart*'. From time to time, during counselling, a counsellor should maintain an eye contact. Eye contact helps in reassuring the client that the counsellor understands her. Shifting of eyes is necessary if the client is shy or hesitates to look at the counsellor. With each counselling session eye contact can help in building trust and friendship.



- **Appropriate Facial Expression** – During counselling, facial expressions of the client and the counsellor should be closely monitored. If the counsellor exhibits a gloomy face, she may make the patient disinterested in her. But ever-smiling face can also mean lack of seriousness. The counsellor should always try to maintain an expression, which shows that she is interested and concerned about the person and also interested to learn about the problem being faced by the client. Some facial expressions of, the client can help the counsellor to evaluate the clients problems.
- **Good Body Posture** – Body postures reveal the mental state of a person. The body posture of the counsellor should be relaxed and should not make the patient doubtful. The patient gets his first impression from the health worker's body posture. The way the client uses his body will also help the counsellor in understanding his situation.
- **Use Verbal Prompts** – Verbal prompts are certain words or sentences that you keep on saying from time to time while talking to someone. Some verbal prompts are 'I see', 'lovely', 'really!' etc. which encourage the client to reveal more of his problems.
- **Easy to Understand Language** – The language that a counsellor uses should be very simple. It should not contain high sounding words. And the counsellor should not give sermons.
- **Making right Body Movement Cues** – Body movement should match with what the counsellor is saying. It can emphasize and provide importance to the message of the counsellor.



## **DO's AND DON'Ts OF COUNSELLING**

Here are a few do's and don'ts that should be followed in practice by a health worker or by you while conducting a counselling session:

<b>DO'S</b>	<b>DON'TS</b>
<ul style="list-style-type: none"><li>▪ Keep the surroundings neat and clean so that the client feels relaxed.</li></ul>	<ul style="list-style-type: none"><li>▪ Do not counsel your client in dirty surroundings.</li></ul>
<ul style="list-style-type: none"><li>▪ Make the client comfortable by being friendly.</li></ul>	<ul style="list-style-type: none"><li>▪ Do not begin the counselling immediately.</li></ul>
<ul style="list-style-type: none"><li>▪ Ensure your client is relaxed and has confidence in you.</li></ul>	<ul style="list-style-type: none"><li>▪ Do not stop your client from talking.</li></ul>
<ul style="list-style-type: none"><li>▪ Listen with attention</li></ul>	<ul style="list-style-type: none"><li>▪ Volume of your voice should not be high</li></ul>
<ul style="list-style-type: none"><li>▪ Try to understand the psychology of the patient.</li></ul>	<ul style="list-style-type: none"><li>▪ Do not dress against the dressing code of your area.</li></ul>
<ul style="list-style-type: none"><li>▪ Speak in a clear and audible tone.</li></ul>	<ul style="list-style-type: none"><li>▪ Do not use exaggerated gestures.</li></ul>
<ul style="list-style-type: none"><li>▪ Speak in soft voice especially to children.</li></ul>	<ul style="list-style-type: none"><li>▪ Do not ask close-end questions if you need more information.</li></ul>
<ul style="list-style-type: none"><li>▪ Dress soberly.</li></ul>	<ul style="list-style-type: none"><li>▪ Do not bring in personal biases in your views.</li></ul>
<ul style="list-style-type: none"><li>▪ Use your non-verbal skills to communicate. With empathy and understanding – remember it is not sympathy. It means that you are able to identify yourself with your client's situation.</li></ul>	<ul style="list-style-type: none"><li>▪ Do not forget to thank the client for sharing her/his problem.</li></ul>

Like Ranjan there are various types of people who seek help at the last minute. Here it is important for a counsellor not to become biased and give up hope, no matter how hopeless the case looks. As

a counsellor, you must never turn away a client by blaming him for seeking help at the last minute.

Another factor that you should keep in mind is that as a counsellor you too have some limitations. Be aware of them as a professional, and do not hesitate to refer the clients to specialists and experts when needed. You cannot solve those problems which need to be looked into by a doctor. But you can give complete and right information so that the patient is able to take care on his own till he reaches a doctor. For example Shamlal knew that, apart from helping Ranjan to take the decision for seeking medical help, he could do nothing else. His client's illness required immediate and specialised care, which he was not capable of delivering. Also, the counsellor should always schedule a return visit, so that client does not feel unwanted and neglected. Or you must visit the client at a common meeting place. This will build a bond of trust and the health worker can also know how the client is coping with the problems.





## SUB UNIT - III

### WHAT ARE RUMOURS AND MISCONCEPTIONS

Sometimes you may have noticed that in some villages under your PHC area, news spreads like a wild-fire. People pass on information from one to another when they meet at a tea-stall, during a house visit or at work. In other words, people love to gossip. This is one of the ways of exchanging information and learning about what's happening all around us. At times however, this harmless interaction may become the source of some talk, which is exaggerated and even baseless. This is known as a rumour. As a supervisor it is important that you monitor the movement of the rumour or incorrect news through the health worker. Rumour is like an uncontrolled wind that sweeps away people's capacity to decide what is right and wrong.

Misconceptions are related to our values and views, which we hold on to as part of our understanding of socio-cultural life. With passage of time, they become strong beliefs, which are passed from one generation to another. People value these beliefs. Some of these may perhaps come in conflict with what you are trying to do. Religious, cultural and social values influence these beliefs and provide them legitimacy. Rumours have short-term effects while misconceptions have long-term effects.

To know what misconceptions are like, let us give you an example. Suppose the people in a village believe that if someone is sick in the house, it is with the 'will of God' and avoid seeking treatment. This belief becomes strong with time and everyone starts believing that praying to God and visiting the faith healers will cure the disease. This may result in unnecessary prolonging of disease and at times lead to death. But it is difficult to dislodge old beliefs that influence people's decisions. Some misconceptions however can be easily removed if the right information is provided and at the right time.



As a Male Health Supervisor, you are required to supervise your health workers in taking measures to prevent the spread of rumours and misconceptions. You in your capacity can also help the health workers to contain rumours and misconceptions by innovative means. You can visit the villages and personally talk to people or community leaders or can seek the help of the Block Extension Educator to arrange folk media performances or group meetings in the village and education through school etc to curb this problem.

### **How to Diagnose and Handle Rumours and Misconceptions**

It is impossible to get rid of old beliefs or rumours without tackling them in a systematic way. Before the health worker actually starts the task of solving the problem, you need to ensure that they take the following '**First Steps**':

- Identify the types of rumours and misconceptions.
- Assess how important they are.
- Identify the measures needed to deal with them by involving:
  - the community; and
  - the health team.
- Identify the people who believe in rumours or have strong beliefs?
- Find out why these people believe in them?
- Prepare a time-frame for removing them.
- Identify your associates who will help you.

### **Ways of removing misconceptions/rumours**

- **Convince by demonstration:** The health worker can convince the clients by showing them the effectiveness of the information that is being given to them as against their old beliefs. Parents can be shown that good nutrition will mean healthy children and not malnourished. It can also be shown that immunisation protects children from various diseases and they should not fear immunisation.

- **Advocacy:** The health worker can seek the help of an acceptor of the programme to tell the people about the benefits. This is called advocacy. For example, The health worker can ask an acceptor of family planning methods to tell the non-acceptor couples about the usefulness of having a small family by citing their own case. This will be more acceptable to people in the community and strengthen the credibility of the programme.
- **Obtain sanction:** The health worker can obtain the participation of the opinion leaders in putting an end to rumours in the community. Opinion leaders have a good understanding of the community and can influence the people to change their age-old practises.
- **Make a visit:** Depending on the spread, the health worker can also decide on an informal visit to the household or organise a group meeting with the key members of the community, or with you.
- **Sustain your motivation:** Motivation should be sustained over a long period of time to be effective. It may not be easy for the health worker to remove a rumour which a person believes in, at once. For this, they will have to be in constant touch with your clients, communities and motivate them from time to time.



You can also make the following kind of chart-plan for supervising the misconceptions or old beliefs in your PHC area.

Rumour	Category of rumour	Characteristics of rumour	How a health worker can handle rumour
Children in the village have had fever after being immunised at the sub-centre since Wednesday	<ul style="list-style-type: none"> <li>▪ Related to child health</li> <li>▪ Immunisation programme</li> </ul>	<ul style="list-style-type: none"> <li>▪ Negative (Short-term measures) needed</li> <li>▪ Created fear among parents</li> </ul>	<p>1. <u>Identify people to be contacted first:</u></p> <ul style="list-style-type: none"> <li>▪ Parents of the children</li> <li>▪ Neighbourhood key members</li> </ul>
		<ul style="list-style-type: none"> <li>▪ Harmful to the immunisation programme</li> </ul>	<p>2. <u>Visits to be undertaken</u></p> <ul style="list-style-type: none"> <li>▪ Visits with the HW/ Anganwadi Worker to the affected homes</li> <li>▪ Repeat visits</li> </ul>
			<p>3. Arranging meetings</p> <ul style="list-style-type: none"> <li>▪ Meeting with local leaders</li> <li>▪ Call a group - meeting of the parents and explain that fever is a normal thing to happen.</li> </ul>



Rumour	Category of rumour	Characteristics of rumour	How a health worker can handle rumour
			<p>4. <u>Advocacy</u></p> <ul style="list-style-type: none"> <li>▪ Bring an old acceptor to the meeting to give an account of her child who was immunised and had fever but is healthier today.</li> <li>▪ Panchayat calls a meeting to explain and sort out doubts.</li> </ul>
			<p>5. <u>Reinforcement</u></p> <ul style="list-style-type: none"> <li>▪ Reinforce your message from time to time when you meet mothers/ parents of young children</li> </ul>

Rumours/misconceptions are very special and people are sensitive about them. Hence they should be handled with lot of care. It requires a bigger effort by you in removing them or making them non-effective. You will need to constantly monitor the process adopted by your health workers to remove rumours/misconceptions. It is true that the misconceptions prevailing in your PHC area is removed, your work will improve substantially and more and more people will come forward to become the acceptors of Reproductive Child Health Programme. For such a task, you will not only need the support of the members of your own health team like the health worker, TBA and Anganwadi worker but also of partners from other departments like a school teacher or the village level worker of the agriculture department. More importantly, you can also ensure that the members of the Panchayat also assist your health workers in

removing wrong views and beliefs related to the programme by conducting discussions in group meetings in Panchayats, in Mahila Mandals, in schools and other public places.

### **Types of Rumours and Misconceptions**

Following is a list of misconceptions old beliefs and rumours which will help you to clearly understand a difference between the three. A clearer understanding of these will help you to guide your health workers better.

MISCONCEPTIONS/ OLD BELIEFS	HERE IS A LIST OF RUMOURS
<ul style="list-style-type: none"> <li>• Sterilisation is only for women since they give birth to children.</li> <li>• Sons are important since they support parents in old age.</li> </ul>	<ul style="list-style-type: none"> <li>• Complications developed by some women in the village after IUD insertion yesterday.</li> <li>• Children who were immunised recently in the village have become ill.</li> </ul>
<ul style="list-style-type: none"> <li>• Educating girls is not important since their main task is to look after the family.</li> <li>• Sex of the child is determined by the mother.</li> </ul>	<ul style="list-style-type: none"> <li>• The Mahila Mandal in their meeting discussed such issues yesterday which have created problems at home for women in the village.</li> </ul>
<ul style="list-style-type: none"> <li>• Sterilisation for men makes them unfit for hard work.</li> <li>• Colostrum for the infant is of no value.</li> </ul>	<ul style="list-style-type: none"> <li>• A woman in the village had twins after being given red tablets by the ANM.</li> </ul>

In rural areas, the people depend more on each other for information. Consequently, you should encourage the health worker to find appropriate methods to contain the spread of misinformation. We have provided the health worker's with the skills and techniques to counter the common rumours and misconceptions in the Health Worker's module. But again you should remember that there is nothing strict about using a technique. You as a Supervisor can ensure that your health workers feels free to adopt any other technique to counter the misconceptions and rumours. However, you should make sure that the health workers plan their action in



consultation with you and not on their own. Your action in consultation with your colleagues and your supervisor will give you more concrete results and build a good health team.

### **Using IPC Skills Effectively to Convince and Motivate People**

Interpersonal communication will enable you to convince the people and gain their confidence. Remember that as a Male Health Supervisor, you should have a good technical knowledge of the subject (Refer to your Maternal and Child Health Modules) as well as a knowledge of the social and cultural values of the area you work in. A sound knowledge will help you to fight against baseless rumours or outdated beliefs like the practice of not giving the mother's 'first milk' to the newborn which is commonly practised in villages.

Let us see an example on how IPC skills can be used effectively to convince and motivate the people. Rumours spread very fast in rural areas. It once happened that twins born to a woman in Alipur village were weak and underweight. Incidentally, the twins died after being administered the polio drops. Rumour spread that the polio vaccine resulted in the death of two children. This made the people of the adjacent areas doubtful and many refused polio vaccination for their children. This rumour could have been handled by seeking complete information about the circumstances under which the infants died. Once investigation and gathering of information has been done through the interview method, the health workers could have met key groups like Panchayats, religious leaders, NGOs and the neighbourhood committees. They could have used their IPC skills in convincing the people about the need to counter such rumours together as a team. Also they can inform you about this and seek your help, if required. This concerted effort will weaken the spread of rumours and their effect on people.

These guidelines can help you in the supervision and you can motivate your health workers to do a much better job in the villages under the PHC.





## **KEY POINTS**

- Interviewing can help in CNA, history taking and counselling.
- Open-ended questions give more information than close-ended questions.
- A good interview is a mix of open-ended and close-ended questions.
- A counsellor should be empathetic, patient, understanding, supportive, helpful and encouraging.
- Counsellor should not be patronising and impersonal.
- Counsellor must be open-minded and not close minded.
- Client should be provided all options and opportunities to help client make an informed choice.
- Counsellor should not be judgemental.
- Counsellor should follow the counselling techniques and steps.
- Apply verbal and non-verbal skills while counselling.
- Keep the surroundings cheerful and clean.
- Refer complicated and high-risk cases to specialised care.
- Monitor rumours/misconceptions scientifically.
- Help health workers diagnose the reasons for spread of rumours and misconceptions.
- Help health workers deal with rumours through opinion leader's intervention or support.
- List out important rumour/misconceptions prevailing in your area.
- Have value for people's strong faith in socio-cultural beliefs.

## **TEST QUESTIONS**

- ✧ What types of questions can be posed in an interview?
- ✧ Where can you use the interviewing skills?
- ✧ What is counselling ?
- ✧ What are the qualities of a good counsellor ?
- ✧ List out the seven counselling techniques.
- ✧ What are the skills that you need to apply while counselling?
- ✧ How will you distinguish between a rumour and misconception?

- ★ Give the example of an important rumour/misconception currently prevailing in your area. Explain how the health worker should handle it?
- ★ Make a list of rumours/misconceptions prevailing in your area.
- ★ List out the methods that you will use to overcome rumours/misconceptions related to acceptance of contraceptives among women.







## UNIT IV

### ***SUPERVISION OF COMMUNICATION ACTIVITIES***

#### **SUB-UNITS**

- **UNDERSTANDING THE NEED FOR SUPERVISION**
- **METHODS OF EFFECTIVE SUPERVISION**

#### **INTRODUCTION**

**A**s a Male Health Supervisor, you need to perform the important function of supervising the health workers and their health activities at the sub-centre as well as in the community. Supervision, in fact, is your most important function. By proper supervision, you will be able to add force and direction to the health activities in your PHC area and ensure that they are a success. Sub-Unit I will help you to understand the concept of supervision of communication activities and its importance in the new RCH Programme.

Your work is not merely to supervise the clinical services being provided by the male health workers. It is beyond that. The new programme stresses that in addition to the supervision of health services, you will also be required to supervise the communication activities performed by the health workers. **In other words, you will**

**need to supervise the 'communication treatment' i.e. how the client is received, served and finally advised to act by your health worker.**

As you prepare yourself for this important role of supervision, you will learn about how and what to supervise. Sub-Unit II explains the methods of effective supervision including supportive supervision. It also explains how supervision is also needed for forming effective partnerships.



### **Learning Objectives**

After going through this unit, you as a **Male Health Supervisor** should be able to:

- ★ Discuss the importance of supervision of communication activities.
- ★ List-out the methods for conducting a supervisory activity.
- ★ Demonstrate the steps in supportive supervision.
- ★ Explain how supervision can help in forming partnerships.

### **SUB-UNIT I : UNDERSTANDING SUPERVISION**

#### **★ CONTENT AREAS**

- ◆ Concept of supervision
- ◆ Why do you need supervision of communication activities
- ◆ What is effective supervision
- ◆ Path to good supervision

### **SUB-UNIT II : METHODS OF EFFECTIVE SUPERVISION**

#### **★ CONTENT AREAS**

- ◆ Methods for conducting supervision
- ◆ Performing supportive supervision
- ◆ Supervising community partnerships



## KEY POINTS

## TEST QUESTIONS



## SUB UNIT - I

### CONCEPT OF SUPERVISION

Supervision is an essential requirement to guide and help the subordinates in their work situations. Supervision is a broad term and it can be carried out through any, some or all of the following ways:



**TRAINING**



**GUIDANCE**



**DEMONSTRATION**



**INDIVIDUAL COUNSELLING AND**



**MONITORING**

Simply defined in your case, *supervision is the process by which you can keep a watch over the work output of your health workers and establish control to improve their work and capacities.* It is your responsibility to see that the work is done in an effective way in which both your health worker as well as you are satisfied.



## **WHY DO YOU NEED TO SUPERVISE**

As a Male Health Supervisor, you will need supervision for:

- ♦ Ensuring that the work allotted to your health worker is completed within time.
- ♦ Assessing the problems that the health workers are facing in implementing the given activities and provide solutions.
- ♦ Promoting team-work as it improves performance and personal relationships. Working in team gives you confidence.
- ♦ Building the gap between the health worker's personal goal and the organisational goal.
- ♦ Providing on the spot guidance to your subordinates.
- ♦ Identifying the Gaps — Many a times as the health worker performs her service to the community, she finds that inspite of her best efforts, the programme or activity fails to achieve results. As a supervisor, you can help the health worker to rethink the reasons for the failure by identifying the loopholes.
- ♦ Controlling a complicated situation — An entire village or community may start disbelieving the health worker because of an incident like the death of a child after immunisation, etc. Consequently, the health worker loses control over her clients. Your effective and consistent supervision can bring relief in such a situation to help the health worker to sort out the issue with the parents, community and opinion leaders.
- ♦ Helping in co-ordination — Supervision can help you to co-ordinate various activities like an immunisation programme, where supervision can act as an adhesive and get together one and all for the success of the programme.

## **WHAT IS EFFECTIVE SUPERVISION?**

'Supervision that brings about a change in the health behaviour of people as well as improves the utilisation of the available health services is known as effective supervision'. As a Male Health Supervisor, you will require certain skills that can help you in an effective supervision. They are:

- **Interpersonal Communication Skills:** You should use effective IPC skills while supervising. Effective IPC skills consists of effective speaking, active listening and non-verbal skills. Deal with the health workers in a friendly and polite manner. Only at times, when the need arises, you can be firm. Simple IPC skills such as verbal, non-verbal and active listening skills can motivate or impress your health workers to give their best.
- **Technical Knowledge:** As a supervisor, you need to possess sound technical knowledge of the programme activities and the various procedures thoroughly. Many a times you may need to demonstrate how each activity is performed which you can do when you possess appropriate knowledge and skill for doing the same.
- **Leadership Qualities:** A good supervisor is a good leader. Your becoming an effective supervisor would depend upon your:
  - Ability to handle various situations.
  - Ability to take responsible decisions.
  - Capacity to understand the feelings and problems of your subordinates.
  - Objectivity in approaching a problem.
  - Willingness to make personal sacrifices to assist the subordinates.
  - Avoiding personal bias and prejudice in making decisions.
- **Remain Committed:** Any activity undertaken must show that you are committed to it. It helps others to take up the activity with the same zeal.

To be a good supervisor in communication, you need to note the following points:

- Help remove pre-conceived notions among the health workers, about community rumours and misconceptions regarding various health issues.
- Develop gender sensitivity.
- Remain alert about existing misconceptions or probability of some false rumours about which you can alert your health worker.



## PATH TO GOOD SUPERVISION



### OBSERVE

- To what extent health worker uses communication in delivering services.
- Does the inter-personal communication input help client to **better** understand the problem.
- What is lacking in IPC of health worker.



### DECIDE

- The gaps you observed in use of communication skills by the health worker.
- The extent to which communication needs of the people by your health worker has been recognised.
- Whether outcome of communication efforts has been effective.



### ACT

- Give specific training on the gaps identified during observation.
- Give on-the-job training on communication skills to the health worker.
- Organise workshops for the health workers at different points in time, on regular intervals.
- Help the health workers to fulfil the communication needs of people to be listened to and provided information with empathy and winning the confidence of people.





## SUB UNIT - II

### METHODS FOR CONDUCTING SUPERVISION

There are several methods for conducting supervisory activities. Broadly, the methods can be divided into the following categories:

➤ **Direct Supervision** -- This is the best method of supervision. Generally, it is difficult to evaluate the work especially of communication activities like IPC counselling or the sessions conducted during village group meetings. It is better if you can observe the entire range of communication activities undertaken by the health worker directly and get immediate feedback. Following is a list of things that you can directly observe by paying visits to the community, to the sub-centre conferences and training sessions:

The IPC skills of health workers and the way he interacts with clients, village panchayat members, school teachers, male adolescents, opinion leaders etc.

- The counselling skills of the health workers.
- The interviewing skills.
- The ability to motivate the community members and form effective partnerships.

➤ **Indirect Supervision** -- Supervision can also be done by indirect observation of records, reports and various data from the field. However, in indirect observation, you are not in a position to give immediate feedback to the health workers. Indirect supervision can be done during the monthly review meetings in the PHC. This only helps you to assess the performance such as the number of meetings held, number of posters distributed, etc. But it does not provide you what was discussed and what emerged out of such efforts. For this direct supervision is a very effective tool.

### **Situations for Supervision:**

A checklist is a tool, which will help you to systematically monitor the quality of services that are being provided by your health workers. The checklist contains a list of programme activities as well as performance standards that are expected from the health personnel. The items in a checklist must be grouped and arranged logically and should not be too long or too short.

Following is a sample checklist, which will help you to monitor the communication process followed by the health worker while delivering the RCH services. If you wish you can add a few more columns to suit your needs.

## Sample Situation

NAME \_\_\_\_\_ VILL./DIST. \_\_\_\_\_

Date	Services	Location	Audience profile	Average number of people attending	Communication method to be used	Follow-up activities	Results	Remarks
	Promotion of contraceptive usage.	Community Hall	Eligible couples	15	Focus Group Discussion	Counselling for the adoption of appropriate method at the sub-centre.		
	Motivate for MTP, Laparoscopy, Mini Laproctomy.	Village School	Mahila Mandal, Anganwadi workers, TBAs	20	Group meeting	Meeting of the acceptors to be conducted by MO at the sub centre.		
	Education on RTI / STI	Youth club	High risk group men and women	8	IPC	Referral Medical check-ups at the PHC.		



## **HOW TO PERFORM SUPPORTIVE SUPERVISION**

Supervision means 'to supervise'. Supportive supervision means 'to support and supervise'. In order to perform supportive supervision, you will not only need to know all the activities of your health worker but you yourself will be able to perform such activities. This will help you to support the health workers in their activities and also teach them on the job.

Supportive supervision is very useful as it helps to raise the confidence of the health workers. It is like an umbrella which provide relief in the scorching sun.

To understand supportive supervision, you can consider a situation where a health worker is finding it hard to counsel a newly married man who has come to the sub-centre to learn about various contraceptive methods. You can then help him to counsel the couple by actually taking the counselling session yourself. The health worker observes your way of counselling the man, and learns the techniques of managing clients. Review with health worker on areas which really helped man decide.

Supportive supervision can be done to help the health worker in:

- Conducting interviews.
- Counselling clients.
- Managing rumours and misconceptions.
- Using IPC skills like verbal, non-verbal and listening skills effectively.

## **SUPERVISING THE MAKING OF COMMUNITY PARTNERS**

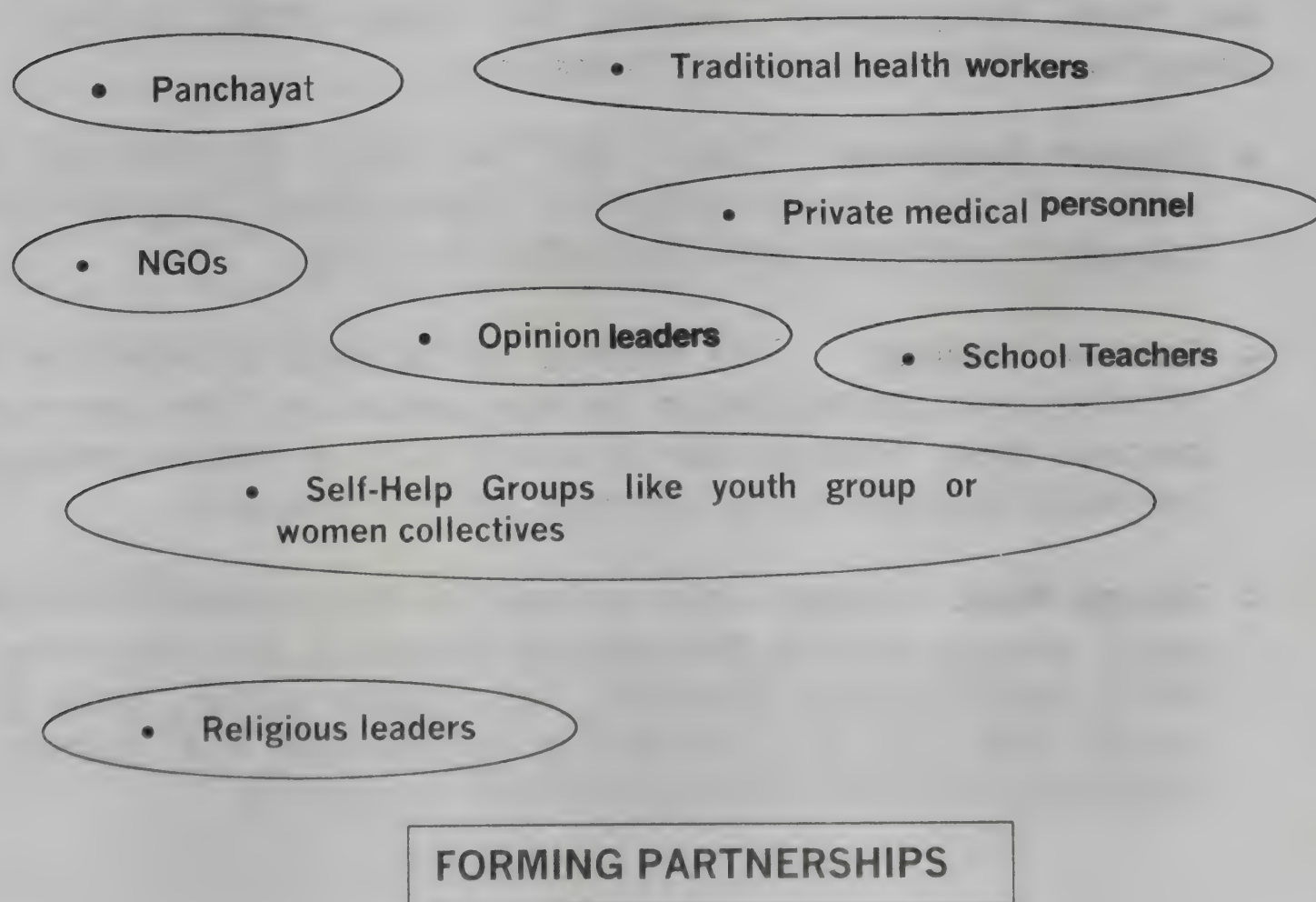
The purpose of the new RCH Programme is to bring in a behaviour change in people. This task is enormous and cannot be done by a few people. Here, you will understand that to bring about a

wide change in the behaviour of the people, we need to seek the help of key persons of the community by making them partners.

As a Male Health Supervisor, you should help the health worker assess the need of a particular programme or activity. For e.g., the success of the immunisation programme may require that partnerships be formed with school teachers, NGOs, village panchayats and parents.

The next stage is to help the health workers form partnerships with the key persons on whom the decision has been taken. You should ensure that the health workers approach these partners with care. They should be able to convince them to be partners so that all come forward to help him willingly. You should also ensure that the partnerships are formed willingly and no force is applied.

Depending on the programme or activity, you can help the health workers form partnerships with the following:





The partners can also be:

- Organised or
- Unorganised

The organised groups are village panchayats, women cooperatives, youth groups etc.

The unorganised groups are housewives, mothers-in-law, husbands etc.

The Health Worker and ANM to form partnership and the Supervisor is to see and help the process.

## METHODS TO INVOLVE COMMUNITY PARTNERS

After having formed the community partners, it is important to identify the problems and the needs of the community jointly. There are many Participatory Learning for Action (PLA) methods of interacting with the community. These are:

- **Chapatti Diagrams:** These can be used to indicate the relationships of various institutions, organisations, programmes or individuals with each other, and within the village.
- **Relative Ranking:** This method can be used to determine the priorities and preferences in the way people and the community perceive them. Partners can be asked to do a relative ranking of the health priorities of the communities they belong to.
- **Village Walk:** Village walks are used to locate areas in a village which are not utilising the services offered by the sub-centre or which require special attention. For a health worker, going for a village walk with his partners is an effective PLA method of collecting first hand information of the community.



## SKILLS FOR DEVELOPING GOOD PARTNERSHIPS

Certain skills are important for developing good partnerships. You should ensure that your health workers possess the following essential skills:

- **Coordination Skills**
- **Good IPC Skills**
- **Interviewing Skills**

Following is a checklist that will be helpful to you to supervise community participation for the pulse polio immunisation programme:

- If there is participation and support of panchayats leaders.
- Meeting religious leaders and getting their support.
- Seeking the support of local doctors, vaid, hakims etc.
- If request of public announcements from religious places been made.
- Concentrating on communities resisting polio drops or are uncooperative.
- Informing people about the location of the booth-post.
- Performing wall writing at places frequented by people.
- Making public announcements using public address system in market places, streets, festivals, melas, weekly gatherings etc.
- Organise drum beatings at important places in the community.
- Enlisting the volunteers for booth/post.



## KEY POINTS

- Supervision is the main activity of an Male Health Supervisor.
- Supervision needed for handling complicated situations.
- Components of effective supervision: IPC Skills, Technical Knowledge, Leadership Qualities.
- Direct and Indirect method of supervision.

- Direct method is most effective.
- Support and supervise gives supportive supervision.
- Supervise for making community partners.
- PLA methods to involve community partners.

### **TEST QUESTIONS**

- ✧ Define supervision.
- ✧ Why should you supervise?
- ✧ What are the skills of effective supervision?
- ✧ Why is direct eye contact with your clients essential?
- ✧ What are the two methods of conducting supervision?
- ✧ Define supportive supervision?
- ✧ Explain supportive supervision with an example.
- ✧ How can you supervise the making of partners?
- ✧ What are PLA methods?

**NOTES:** For further details about supervision, refer to Management Component of this module where further details are available.



# Maternal Health

for

*Health Assistant (Male)*







## **UNIT 1**

### ***ANTE-NATAL CARE***

#### **LEARNING OBJECTIVES:**

At the end of this sub-unit, you should be able to:

- assist the HW(F) to ensure ante-natal care to all pregnant women.
- assess the risk factors and do the appropriate referral.
- ensure T.T. immunization and distribution of iron and folic acid tablets depending on haemoglobin estimation.
- list and understand implications of danger signals.

#### **CONTENTS:**

- 1.1. Introduction
- 1.2. Aims and importance of ante-natal care
- 1.3. Checking of height, weight and blood pressure
- 1.4. Routine investigations
- 1.5. Assessment of risk factors during pregnancy
- 1.6. Tetanus Toxoid immunization
- 1.7. Iron & folic acid distribution
- 1.8. Early recognition of complications and urgency in referral
- 1.9. Health education and counselling
- 1.10. Record maintenance
- 1.11. Collaboration with HW(F) Dais, Anganwadi Workers and Community leaders
- 1.12. Supervisory check-list
- 1.13. Self-assessment questions

### **1.1. Introduction:**

Effective ante-natal care to a pregnant woman can improve the health of the mother and also improve the chance of giving birth to a healthy baby. Regular monitoring during pregnancies can help to ensure that complications are detected early and treated before they become life-threatening emergencies. However, pregnancy is an ongoing risk process and even with the most effective screening tool currently available one cannot predict which individual will develop complications. Hence every mother needs special care and education on when and where to go if complications arise.

### **1.2. Aims and importance of ante-natal care**

As you know the aims and importance of ante-natal care are:

- to promote and maintain good physical and mental health during pregnancy.
- to monitor progress of pregnancy.
- to detect early and treat appropriately medical and obstetrical conditions that would endanger the life or impair the health of pregnant woman or baby.
- to ensure a mature live and healthy infant.
- to prepare the woman for delivery, breast-feeding and subsequent care of her child.
- to encourage the concept of having regular ante-natal check-up and proper care of the pregnant woman even in an apparently normal pregnancy.
- to prevent maternal as well as neonatal tetanus.
- to facilitate health education regarding diet, exercise, rest and avoidance of unnecessary travel during pregnancy and preparations for delivery.



You may wonder why women need early registration during first 16 weeks of pregnancy. This is to:

- assess the health status of mother and to obtain baseline information on B.P., Hb, weight etc.
- screen for risk factors early and manage appropriately by referring to PHC/CHC or district hospital.
- recall easily the last menstrual period.
- get MTP done in unwanted pregnancy if required (it can be done safely between 6 to 10 weeks).

Some pregnant women will come themselves to the antenatal/MCH clinic at sub-centre or villages. Many may not come to the clinic/village. Relatives, Dais, AWWs, depot holders, school teachers, as well as friends and neighbours can help to give you information about pregnant women in the community which you can pass on to the HW (F).

At least 3 check-ups are advised after confirmation of pregnancy and registration. Optimal numbers of check-ups are between 9 to 10.

**You must ensure that every pregnant woman must get at least 3 check-ups during pregnancy other than registration.**

The first check-up after registration is in the second trimester at 16 to 20 weeks and next two in the third trimester at 32 weeks and 36 weeks.



Fig.1.1 Mother and Infant Immunization Card

**As a health worker you must know the activities of three check ups after registration which is done by female health worker/assistant**

*The activities of three check-ups after registration are as follows:*

**1<sup>st</sup> Check-up: end of 4<sup>th</sup> month (16-20 weeks)**

- Screen for risk factors and medical conditions
- Record BP, weight and height
- Screen for anaemia
- Give tetanus toxoid
- Provide education for nutrition
- Develop individualized birth plan

**2<sup>nd</sup> Check-up: 28 to 32 weeks**

- Record BP weight
- Abdominal examination to assess for intra-uterine growth retardation (IUGR), twins etc.
- 2<sup>nd</sup> dose of tetanus toxoid
- Anaemia prophylaxis/treatment
- Develop individualized birth plan
- Health education

**3<sup>rd</sup> Check-up: 36 weeks onwards**

- Record BP weight.
- Detect-pregnancy induced hypertension.
- Abdominal examination to identify foetal lie/presentation to detect IUGR.
- To rule out if head is bigger than pelvis in primigravida after 37 weeks.
- Update individualized birth plan with the trained birth attendant and family.



- Health education: Diet, rest, IFA tablets consumption, danger signs and where to go when any complications arise.

You should encourage her to visit more often, especially in the third trimester of pregnancy.

### **1.3. Checking of height, weight & blood pressure**

#### **Height**

A short woman with height less than 145 cms may have a small pelvis, hence may have problems during delivery. Such woman should be referred to MOPHC. While measuring height the pregnant woman should stand against the scale with her feet touching the wall/scale and head held straight.

#### **Weight (kg)**

Adult women wearing light clothing are requested to stand erect in such a way that the weight is distributed evenly on the platform of the balance, before taking weight. Weight measurement is done to the nearest 100 gms. Weight must be recorded at every ante-natal visit. Weight gain during the first trimester is minimal. However, the expected weight gain during pregnancy is around 10 kgs. After first trimester women gain around 2 kgs every month or 0.5 kg/week. The weight she should have gained since her last visit should be estimated using the calculation of 0.5 kg/week for the number of weeks since her last visit and compared against actual weight gain observed. An excessive weight gain (more than 3 kgs in a month) should arouse a suspicion of pre-eclampsia/twins. You must refer woman with excessive weight gain to MOPHC. Underweight women and women gaining less than 2 kgs should also be referred to AWW for food supplementation. In follow-up visits it must be checked that she is gaining adequate weight. In spite of supplementary feeding, if weight gain is poor she must be referred to M.O. PHC



## Blood Pressure Recording

You must record the BP of pregnant woman correctly at every visit.

- a. The systolic blood pressure is defined as the BP at which the sounds first appear and diastolic blood pressure as the BP at which the sounds tend to get muffled. In pregnancy often the disappearance of the sounds occur when the BP reading is very low. (Note the diastolic pressure if stethoscope is available). The BP is recorded as follows.
- b. Ask the patient to sit or lie down comfortably and relax.
- c. Ensure pointer on the dial is at zero by adjusting with the knob attached to the dial.
- d. Fix arm cuff on the upper part of either arm.
- e. All clothing should be removed from the arm. The cuff should be applied closely to the upper arm, with the lower border not less than 2.5 cms from the cubital fossa (elbow).
- f. Feel the pulse at the wrist by either arm.
- g. Tighten the knob above the rubber bulb and inflate the cuff with your right hand.
- h. The manometer is placed so as to be at the same level as the observer's eye.
- i. Needle of the dial will show deflection as the pressure increases within cuff.
- j. Keep on inflating the pressure by pressing bulb with fingers on pulse. When pressure in cuff increases more than the blood pressure, you will not feel the pulse.
- k. Note the reading on the dial just at the point above which the pulse is not palpable and below which the pulse is palpable. This is the systolic blood pressure of the woman. For example, if the reading on the dial shows 120 at which you stop feeling the pulse and if the dial moves below 120, you can feel the pulse, then the systolic BP of the women is 120 mm Hg.
- l. Deflate the cuff by loosening the screw above the bulb.
- m. The blood pressure reading is normally less than 140 mm Hg.

- n. If it is more than 140 mm Hg, take blood pressure again, make sure the expectant mother is calm and not anxious.
- o. **If stethoscope is available** the radial pulse is palpated while the cuff is inflated to a pressure of 30 mm Hg above the level at which radial pulsation can no longer be felt.
- p. The stethoscope is then placed lightly on the cubital fossa.
- q. The pressure in the cuff is lowered, 5 mm Hg at a time, until the first sound is heard, which is the systolic pressure.
- r. Continue to lower the pressure in the cuff until the sound becomes suddenly faint or muffled. This is the diastolic pressure. The BP is expressed as systolic/diastolic(s/d).
- s. Blood pressure must be recorded at every ante-natal visit. Abnormal blood pressure is a pressure of 140 mm Hg systolic or more which is sustained (two consecutive readings at least 6 hours apart after rest). When it develops after 20 weeks of gestation it is suggestive of pre-eclampsia. Women with blood pressure 140/90 or above but less than 160/110 mm Hg should be referred to PHC. Blood pressure of 160/110 mm Hg is a danger signal and the woman must be referred to CHC/FRU immediately. If BP is 140/90 with proteinuria (presence of protein in urine) she should be referred to FRU.

#### 1.4. Routine investigations

In routine investigations haemoglobin is estimated, urine is examined for albumin and sugar.

##### I. Haemoglobin Estimation

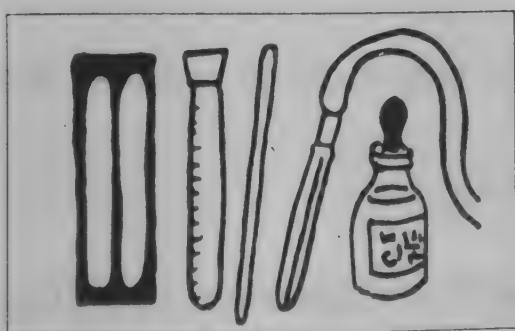


Fig. 1.2  
Materials for Haemoglobin  
Estimation by Sahli's Method

##### Materials (Fig. 1.2)

- Sahli's haemoglobin meter
- Graduated tube
- Sahli's pipette marked to 0.02 ml.
- Filter paper
- Dropper
- Glass rod
- N/10 hydrochloric acid
- Sterile lancet



Why and when you should do Hb estimation:

- Estimation of haemoglobin is done to check if the pregnant woman is suffering from anaemia. It is important as many women suffer from anaemia and its complications, which can even cause death.
- Hb estimation is done during pregnancy at the first visit and at 32 weeks routinely.
- If anaemia is present then estimation is repeated 4 weeks after iron and folic acid therapy. If no improvement is seen after 4 weeks refer the case to M.O.

### Method of Haemoglobin Estimation

Hb estimation is done by Sahli's method by using haemoglobinometer Fig. 1.2 shows some of the materials used for estimation of haemoglobin by this method.

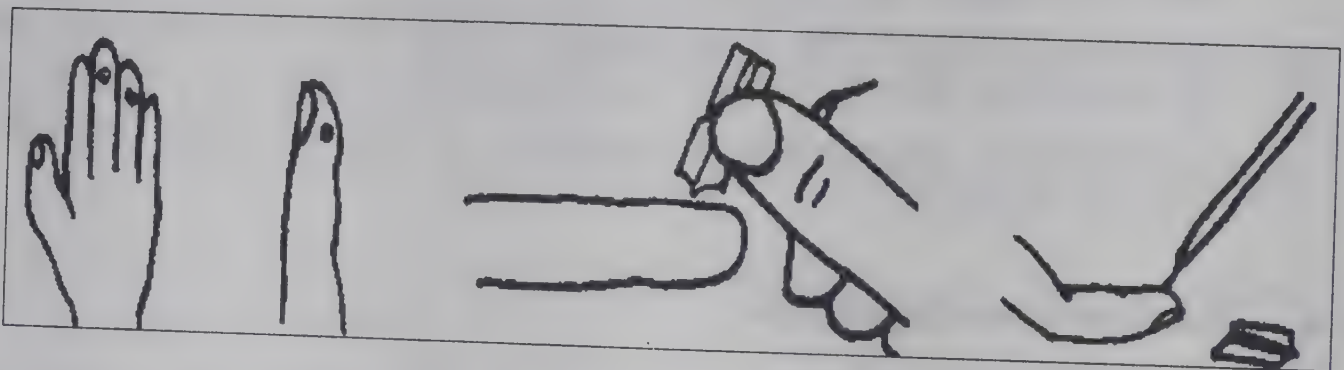


Fig. 1.3 Blood Collection by Capillary Method

The steps to be followed by in haemoglobin estimation by Sahli's method are given below:

- Blood is collected from the side of the ring or middle finger by the finger prick. Fig. 1.3
- For this clean the site with spirit swab.
- Prick the finger firmly and rapidly.
- Wipe away the first drop of blood with cotton wool (don't squeeze the finger for blood drop to appear as the tissue fluid may be squeezed and may give wrong results).



- Wait for another drop of blood to appear.
- Draw the blood in the pipette upto 0.02 mark; do not allow air bubbles to enter.
- Keep the graduated tube ready upto 20 mark with N/10 hydrochloric acid.
- Draw the blood as mentioned above.
- Wipe the extra blood from the outside of the pipette.
- Slowly blow out the blood into the acid in the graduated tube.
- Rinse the pipette by drawing and blowing out the acid solution 3 times.
- Allow standing for 5 minutes.
- Place the graduated tube in the haemoglobinometer.
- Compare the colour of diluted blood in the tube with the reference tube.
- If the colour is same or lighter, then the haemoglobin value is less than 4 gms %.
- If the colour is darker than the reference tubes, continue to dilute by adding N/10 HCL drop by drop.
- Water can also be used at this stage to dilute.
- Stir with the glass rod after adding each drop.
- Remove the rod and compare the colours of the two tubes.
- Stop when the colours match. Note the mark reached.

## **II. Urine Test for Albumin and Sugar**

Test for presence of albumin and sugar in urine during every ante-natal visit.

Use Uristix method for estimation of albumin and sugar in urine.

Boil urine in a test tube and add few drops of acetic acid. If turbidity persists, it indicates presence of albumin.

Do Benedict's test for sugar: Take 5 ml. of reagent in a test tube and add 8 drops of urine boil for 2 minutes and look at the

bottom of test tube for yellow-green orange or brick red precipitate indicating presence of sugar. Green precipitates are not abnormal.

### **1.5. Assessment of risk factors during pregnancy:**

As you already know that all pregnant women are at risk of complications. There are some conditions the presence of which make the pregnant woman exposed to a higher risk of complications and threat to life of mother and baby.

***Women at risk in pregnancy or delivery are those with:***

- a) weight less than 38 kgs at first trimester.
- b) short stature (less than 145 cms or 4 feet and 10 inches).
- c) age less than 18 years or more than 35 years.
- d) problems in previous pregnancy.
  - Operative delivery.
  - Still birth/neonatal death in previous pregnancy.
  - Complicated delivery such as prolonged labour, retained placenta, ante-partum and post-partum haemorrhage and sepsis.
  - History of more than four deliveries.
  - History of repeated abortions.
- e) History of illness such as heart disease, diabetes and T.B., malaria, anaemia and other medical problems.
- f) Problems in present pregnancy like:
  - Bleeding anytime during pregnancy
  - Abnormal presentation
  - Pregnancy induced hypertension
  - Severe anaemia
  - Twins, over-distended uterus
  - Floating head in a primigravida at 38<sup>th</sup> week or later
  - Very big or very small baby
  - Pre-term labour (earlier than 37 weeks)

**For the following risk factors refer to PHC:**

The following risk factors require referral to PHC.

- Short statured women.
- Age less than 18 years.
- History of any medical problem.
- Height of uterus not corresponding to period of gestation.
- Sluggish/loss of foetal movement.
- Hb <10 gms.
- Fever more than 3 days.

**For the following risk factors refer to FRU:**

- Bad obstetric history i.e. previous still born.
- Bleeding during pregnancy (more than 12 weeks).
- Pregnancy induced hypertension with proteinuria (pre-eclampsia).
- Abnormal presentation.
- Multiple pregnancy/over distended uterus.
- Grand multipara i.e. four or more deliveries in the past.
- Previous history of operative delivery e.g. caesarean section
- Age more than 35 years.
- Floating head in a primigravida at 38 weeks or later.
- Pre-term labour.
- Premature rupture of membranes (if labour pain does not start within 6-8 hours of rupture of membranes).
- Very big/very small baby.

**For the following danger signs refer to FRU:**

Presence of the following signs makes pregnant woman at risk to life threatening conditions. Hence you should refer them to FRU as soon as possible:

- Bleeding
- Breathlessness (severe anaemia)



- Convulsions, severe headache
- Swelling of face and hands
- High grade fever
- Labour pains for more than 12 hours

### **1.6. Tetanus Toxoid immunization**

Explain to the pregnant woman that T T immunization protects her and her newborn baby against tetanus, which is a serious disease with a high mortality. T T immunization must be given to all pregnant women and there are no contraindications. It is given as intra-muscular injection of 0.5 ml.

- The first injection is given at the time of the first contact with the pregnant woman.
- The second injection is given after one month. If the woman had received tetanus toxoid during a previous pregnancy less than 3 years ago, only one injection is sufficient. However, in case of doubt give 2 injections.
- You must ensure that the injections must be completed at least one month before delivery. There may be slight pain at the injection site for a day or two.

Tetanus toxoid must be administered under proper aseptic precautions

- It is given at the outer aspect of upper one-third of the upper arm. Clean the part with cotton and spirit.
- Allow it to dry.
- Stretch the part of the skin between the thumb and finger by holding the arm from beneath the axilla.
- Prick the prepared part and withdraw the piston to see whether there is blood coming or not. If no blood is coming then give the injection. If blood is seen coming into the syringe then withdraw the needle and repeat the procedure at different site with another needle .

The tetanus spores are widespread in the environment, especially in the rural areas where there are a large number of animals living in close proximity. It is therefore important that high T.T immunization coverage levels are sustained and clean delivery practices continued even if there are no cases of neonatal tetanus.

### **1.7. Iron & folic acid distribution:**

Prophylactic iron tablets should be given to all pregnant women after 16 weeks of gestation till three months after delivery.

### **1.8. Early recognition of complications and urgency in referral:**

All pregnant women are at risk of complications and in some women these complications can occur without any warning. Therefore the community, family members of pregnant women and pregnant women themselves must be educated about the danger signals. It is also important that all pregnant women and their families are aware of the nearest hospital, how to reach it, to make advance arrangements for transport in anticipation of the emergency. They should keep sufficient money for such an emergency. Some complications require immediate response, as the time between onset and death in a woman can be very short.

Delivery of 'high-risk' women in the hospitals will reduce the number of avoidable serious life-threatening complications such as rupture uterus, septicemia and haemorrhage and reduce maternal and peri-natal mortality and morbidity due to these complications.

You must teach the pregnant woman, her family as well as the community about the need to identify the danger signals and seek immediate medical help at CHC/FRU.

#### ***Danger signals are:***

- Vaginal bleeding or spotting.
- Pallor with breathlessness or marked palpitations.
- Dizziness, blurring of vision, headache or vomiting.



- Fits/convulsions.
- Marked reduction in urinary output.
- Severe abdominal pain.
- Pre-term labour before 37 weeks and premature rupture of membranes before 37 weeks.
- Premature rupture of membranes and no labour pains within 10-12 hours.
- Leaking before 37 weeks must be referred to PHC.
- Fever during ante-natal period for more than 3 days.

## **1.9. Health Education and Counselling**

You should educate the woman about the following:

### **(1) Drugs**

Drugs are not to be used in the first trimester unless required for a life-threatening emergency. The pregnant woman should be advised to consult a doctor if there is any such problem. She should be told not to do self-medication.

### **(2) Bath**

The woman should have daily bath and keep her body clean and wear clean loose clothes. She must keep vulval region clean to prevent infection.

### **(3) Rest**

The mother needs to rest on the side for about two hours in the afternoon and get at least 8 hours of sleep at night. Rest improves the circulation to the foetus. Short periods of rest in between ordinary day-to-day activities should also be taken. Ordinary day-to-day routine activities should be continued in normal pregnancy. However heavy manual work is not advisable. It is important to advise the woman and other family members that the woman gets adequate rest so that family responsibilities are shared and pregnant woman gets the rest she needs



#### **(4) Food and Nutrition**

Pregnant women from poorer socio-economic groups need to take an extra meal of the family food every-day. Pregnant women should preferably take local seasonal foods which are rich in iron (Example:- green leafy vegetables, spinach, cabbage and other available green vegetables). You are already aware that under-nourished women are likely to suffer from anaemia, give birth to low birth weight babies and both mother and baby are susceptible to illness.

#### **(5) Preparing for Delivery**

You should discuss with the woman and family members about the need for institutional delivery.

The community, family members of the pregnant women and the woman herself must be told that even in low risk cases sometimes complications develop suddenly with serious consequences to mother and child. So it is better for the woman to have an institutional delivery by trained personnel. In case they are not willing for institutional delivery, they should be provided with DDK. In case the DDK is not available they should be advised to buy a new blade and thread and keep them handy. The thread should be boiled for 20 minutes before use.

You should also ask the woman and family to keep old clean cotton cloth for mother and for the newborn. It is important that these are clean to prevent infection. Clothes should be washed with soap and sun dried. They should be kept away from dust.

It is very important that all women who are pregnant, their family members and the community must be informed regarding the nearest hospital so that they can be taken there immediately if there is an emergency. They must also make some arrangements in advance for transportation so that no time is lost if the woman has to be rushed to a hospital. Blood transfusion is often required for

obstetric emergencies and family members and friends must accompany the woman to donate blood.

#### **(6) Education for Breast-Feeding and Breast Examination**

All pregnant women must be advised on early and exclusive breast-feeding and care of the newborn. Care of the breasts should start during pregnancy.

Everyday while having a bath, the mother should wash the breasts well.

***You should give advice regarding other aspects:***

- a. Intercourse is best avoided after 36<sup>th</sup> week of pregnancy and for six weeks after delivery.
- b. Long travel by bus or bullock cart should be avoided in the first three month or after twenty-eight weeks of pregnancy.
- c. Teeth must be cleaned daily and dental caries must be treated.
- d. The pregnant woman should not smoke as it affects the growth of the baby.
- e. Bowels should be regulated, as constipation can be troublesome. This can be avoided by advising her to drink plenty of fluid especially warm water on getting up in the morning. Fruits and green vegetables in the food will all help to keep the bowels regular. Strong purgatives are to be avoided.

**For details of counselling refer to Communication Block.**

#### **1.10. Record Maintenance:**

Entry should be made as early as possible in the appropriate register/forms.



### **1.11. Collaboration with Dai/Anganwadi Workers and Community Leaders:**

Relatives, Dais, AWW, depot holders, school teachers, as well as friends and neighbours can help to give you information about pregnant women in the community.

In addition the members of the community should also be made aware:

- when to go to referral centre by informing them about danger signals of pregnancy (refer to danger signals).
- where to go for care by explaining location of institutions (should know where the FRU/nursing home is).
- how to go – providing information about the transport and approximate cost.

#### **Key points : (Ante-natal care)**

- Planning for provision of services.
- Importance of ante-natal care.
- Early registration of pregnant women.
- Follow-up of ante-natal woman at specified intervals.
- Referral of high-risk pregnant woman.
- Management of minor ailments during pregnancy.

### **1.12. Supervisory Check-List**

You have to supervise the record maintenance as well as counter check from the community the services provided by the HW(M). Refer to Block on Management.



Tick <input type="checkbox"/> if applicable and <input type="checkbox"/> if not	<b>A. Preliminaries</b>
	<ol style="list-style-type: none"> <li>1. Conveys the importance of early registration of pregnancy.</li> <li>2. Ensures cleanliness at place of work.</li> <li>3. Ensures adequate light at place of work.</li> </ol>
	<b>B. General Examination</b>
	<ol style="list-style-type: none"> <li>1. Observes built and nutrition</li> <li>2. Measures height as follows : <ol style="list-style-type: none"> <li>a. ensures patient has taken off shoes,</li> <li>b. makes patient stand against wall/firm surface, and</li> <li>c. uses a scale/firm object to mark the height from the top of the patient's head.</li> </ol> </li> <li>3. Take weight as follows: <ol style="list-style-type: none"> <li>a. Checks zero error on the weighing machine before taking patient's weight.</li> <li>b. Ensures patient takes off slippers, and</li> <li>c. Compares the weight with previous weight if known.</li> </ol> </li> <li>4. Inspects for pallor on nails, conjunctiva and tongue in good light.</li> <li>5. Inspects for jaundice in good light.</li> <li>1. Records pulse for one minute.</li> <li>2. Records BP- <ol style="list-style-type: none"> <li>a. makes patient sit comfortably/lie down.</li> <li>b. checks zero error on the dial.</li> <li>c. ties the cuff properly over the arm.</li> <li>d. places the stethoscope over the front of the elbow.</li> <li>e. records BP correctly.</li> </ol> </li> <li>7. Can do Hb estimation</li> <li>8. Can test urine for albumin and sugar</li> <li>9. Counsels about adequate diet</li> <li>10. Explains about adequate rest <ol style="list-style-type: none"> <li>a. gives Iron-Folic acid tablets to the patient</li> <li>b. advises patient to take tablet daily</li> </ol> </li> <li>11. <ol style="list-style-type: none"> <li>a. explains about TT immunization</li> <li>b. gives immunization in the correct dose</li> </ol> </li> <li>12. ensures a gap of at least one month between 2 doses</li> </ol>

### 1.13. Self-assessment questions:

1. List the leading causes of maternal mortality in India.
2. Enumerate the risk factors for which you will refer the pregnant woman to FRU?
3. What are the danger signs during pregnancy for which you must refer to FRU?
4. When is Injection TT administered to the pregnant woman?

**Broad Guidelines for Referral During Pregnancy and Child Birth**

<b>Complication</b>	<b>Action</b>
Elderly gravida with long period of infertility.	More frequent AN check-up. Refer at 36-37 weeks to CHC/FRU.
Teenage gravida.	More frequent ante-natal care. Risk of anaemia/PIH. Hb estimation. Refer to PHC for delivery.
Grand multi-para, para four and above.	Watch for anaemia. Hb estimation. Refer to PHC for delivery.
Repeated abortions at approximately same period of gestation.	Refer to Health Worker Female.
Previous repeated still births.	Refer to CHC/FRU for delivery.
Previous Operative (C.S.) delivery.	Refer to CHC/FRU for delivery.
Past history of IIIrd stage complications.	Refer to CHC/FRU for delivery.
Minimum bleeding P/v in 1 <sup>st</sup> trimester with abdominal pain (could be ectopic).	Refer to CHC/FRU. Relatives to accompany for blood donation.
Profuse bleeding P/V in 1 <sup>st</sup> trimester with pain abdomen.	Refer to PHC if facilities are available for evacuation otherwise to CHC/FRU.
H/o passing vesicles	Refer to CHC. Relatives to accompany for blood donation.

Ante-partum haemorrhage	Refer direct to CHC/FRU. Relatives to accompany for blood donation.
Fever with chills and rigors	Refer to PHC for diagnosis and treatment. Further ANC by health worker. Refer to PHC for delivery.
Obstructed labour	Refer to FRU and ensure that relatives accompany them
Eclampsia	Refer to FRU and ensure that relatives accompany them
Post-partum haemorrhage	Refer to FRU and ensure that relatives accompany them
Sepsis (after abortion/delivery)	PHC/FRU and ensure that relatives accompany them



## **UNIT 2**

### ***SAFE ABORTION***

#### **LEARNING OBJECTIVES**

At the end of this unit, you should be able to:

- identify women who may need safe abortion services and refer them.
- explain the dangers of unsafe abortion and period of pregnancy when safe abortion is possible.
- identification of women with complication of abortion.
- counsel and educate the individual, family and community about safe abortion services.

#### **CONTENTS**

- 2.1. Introduction
- 2.2. Dangers of unsafe abortion
- 2.3. Indications for MTP and the period upto which MTP is done legally under MTP act.
- 2.4. Health education/counselling
- 2.5. Supervisory check-list
- 2.6. Self-assessment questions

#### **2.1 Introduction:**

Approximately **11%** maternal deaths are due to unsafe and septic abortions. Medical Termination of Pregnancy was legalized in 1971 in India. You have to play a vital role by

informing women, family and community about the provisions under MTP act, where services are available to ensure safe abortion and follow-up care. During MTP the product of conception is removed from the uterus, under safe clean conditions by a qualified person, after assessing the woman's health condition provided the case fulfils the criteria (indication) for performing MTP. MTP is done in a hospital or health care centre, which has been approved by government and has the required facilities and manpower.

### **Identification of Women Who Need Safe Abortion Services:**

- A woman who already has child/children and became pregnant because of not using any contraceptive method (will know from eligible couple and child register).
- Woman who became pregnant due to failure of contraceptive method. (will know from woman).
- Unmarried woman/widow or victims of rape who becomes pregnant (will know from Dai, Anganwadi Worker or any community member).

You should know the centres with facility for providing MTP services and refer the woman to these centres. (PHC/CHC/FRU/Nursing homes)

### **2.2. Dangers of Unsafe Abortion:**

Whenever opportunity arises you must inform the community about the dangers of unsafe abortion. Some of which are enumerated below :

- Infections (sepsis) resulting in various life-threatening situations like peritonitis, septicemia, renal failure and death.
- Excessive vaginal bleeding resulting in shock, and death.
- May result in injury to urinary bladder and rectum.



### **2.3. Indications for MTP and the Period upto which Abortion is done Under the MTP Act:**

- If the continuation of pregnancy will endanger the life of the woman and cause grave injury to her physical and mental health.
- If there is danger of the child being born with handicaps or there is risk of child having physical and mental abnormalities.
- If the pregnancy had been caused by rape.
- If the pregnancy is due to failure of contraceptive methods by woman or man.

MTP can be done upto 20 weeks but the best period for safe abortion is between 6-10 weeks of gestation.

### **2.4 Health Education/Counselling:**

- You should make the woman, family and community aware that use of contraceptive is better than going for MTP as the complications are more in MTP.
- Abortions are to be done in recognized centres by trained personnel between 6-10 weeks to minimize the complications.
- Abortion performed after 10 weeks gestation is associated with more complication even if done by trained personnel.
- Abortion by untrained personnel can result in life threatening situation. It can also lead to infertility, ectopic pregnancy, fistula and chronic pelvic inflammatory disease.
- It is advisable to use contraceptives after abortion instead of repeated MTPs.

***You should counsel the woman about the MTP procedure (Refer to Block on Communication).***



**Key points : (Safe Abortion)**

- Knowledge of nearest centres with facilities for performing MTPs.
- Knowledge of period when MTP is safe.
- Counselling regarding safe abortion and need for appropriate contraception.
- Follow-up of women who had MTP.

**2.5 Supervisory check-List**

You have to supervise the HW(M) when he is giving health education and counselling on MTP services under the RCH programme. While supervising you must ensure that he:

<b>Tick ✓ if applicable and X if not</b>	<b>A. Preliminaries</b>
	1. Can guide to the centre where MTP can be done.
	2. Tells the client about the complications of unsafe abortion
	<b>B. Post MTP follow-up</b>
	1. Advises about contraception .
	2. Advises about next follow-up visit.

You must ensure that he maintains records as per format. Refer to Block on Management.

**2.6 Self-assessment Questions:**

5. What are the dangers of unsafe abortion?
6. Which period of pregnancy is best for safe abortion/MTP?

## **UNIT 3**

### ***CONTRACEPTION***

#### **LEARNING OBJECTIVES**

At the end of this unit, you should be able to:

- explain the various contraceptive methods and list the benefits, side-effects and contraindications for each method and appropriate referral.
- provide health education/counsel the women, family and community

#### **CONTENTS**

- 3.1. Introduction
- 3.2. Estimation of eligible couples
- 3.3. Natural methods of contraception
  - 3.3.1. Breast-feeding
  - 3.3.2. Customary separation or abstinence of marital partners after birth of baby
  - 3.3.3. Sex without penile vaginal intercourse
  - 3.3.4. Coitus interruptus (withdrawal method)
- 3.4. Condoms
  - 3.4.1. Mechanism of action
  - 3.4.2. Advantages

- 3.4.3. Disadvantages
- 3.4.4. Selection of condom
- 3.5. Spermicides
  - 3.5.1. Mechanism of action
  - 3.5.2. Indications
  - 3.5.3. Advantages
  - 3.5.4. Disadvantages
  - 3.5.5. Contraindication
  - 3.5.6. Instructions to clients
- 3.6. Oral contraceptive pills
  - 3.6.1. What is (Mala-N/Mala-D) Oral Pill?
  - 3.6.2. Advantages
  - 3.6.3. Disadvantages
  - 3.6.4. Selection of acceptors
  - 3.6.5. Messages to be given to community
  - 3.6.6. Clearing myths about pills
- 3.7. Copper T
  - 3.7.1. Counselling
  - 3.7.2. Selection of cases for IUD
  - 3.7.3. Contraindications
  - 3.7.4. Sterilisation of equipment
- 3.8. Permanent methods
- 3.9. Health education/counselling
- 3.10. Monitoring/reporting as per format
- 3.11. Supervisory check-list
- 3.12. Self-assessment questions



### 3.1. Introduction:

Contraception includes all methods used to prevent conception and thus regulate fertility. Each method prevents pregnancy in a different way. The contraceptive method may be:

- Temporary (spacing), for delaying first pregnancy or spacing the childbirths.
- Permanent (sterilization), for limiting the family after achieving the desired family size.

#### **SPACING OF CHILDREN:**

- ensure health of the mother,
- enable her to care and breast-feed her child, and
- prevents low birth weight of the next infant.

Many women may like to use contraceptives to avoid pregnancy but they are not aware of its availability. Thus there may be unplanned pregnancies and women may seek abortions which may be performed by untrained persons under unhygienic and unsafe conditions. This may result in complications and even death of the women. Easy accessibility to good quality family planning services is basic right of all women to prevent pregnancy, unsafe abortions and childbirth related deaths and long-term morbidity.

The risks associated with contraception are much less than risk of pregnancy, M.T.P. and childbirth. Therefore it is better to avoid pregnancy by use of contraceptives.

Regular contact between you and the client is very essential for satisfactory use and continuation of contraceptive methods. Objective of this block is to enable you to have necessary knowledge about different contraceptive services including counselling and appropriate referral.

### **3.2. Estimation of Eligible Couples:**

The eligible couple and child register (which is maintained and updated by you) will be able to provide the number of couples requiring spacing/permanent methods of contraception. According to the updated record calculate the number of couples who will require various contraceptive methods viz. condoms, oral pills, Cu-T and referral for sterilization.

It is estimated that in India women in reproductive age group i.e 15-45 years who are married constitute about 17% of the population. In the sub-centre area with a population of 5000 around 850 women are expected to be in this age group. The age group requiring priority attention for family planning services is between 20-30 years. They are to be given advice on birth spacing as a health measure and are to be informed on use of contraceptives. Women with 2 children or less can be counselled for birth spacing and based on their number in your area the number of Cu-T/oral pills/condom requirement can be calculated.

### **3.3. Natural Methods of Contraception:**

Some of the natural methods of contraception are :

- 3.3.1. Breast-feeding
- 3.3.2. Customary separation or abstinence of marital partners after birth of baby.
- 3.3.3. Sex without penile vaginal intercourse.
- 3.3.4. Coitus interruptus (Withdrawal method).

#### **3.3.1. Breast-feeding**

Breast-feeding can be used as an effective method of contraception for about 6 months provided the mother practices exclusive breast-feeding i.e. no substitute of breast milk and interval



between feeds more than 6 hours. Further menstrual period must not have returned after delivery.

**Advantages:** Breast-feeding as a method of contraception is economical, effective if used properly, and it promotes bonding between mother and baby.

**Disadvantages:** Effectiveness greatly decreases in following situations:

- When breast-feeding is no longer exclusive (i.e. liquids or food are substituted for a breast milk) or any two breast-feedings are more than 6 hours apart.
- After 6 months post-partum even if menstruation has not started.
- When menses returns.

### **3.3.2. Customary separation or abstinence of marital partners after birth of baby:**

In certain communities, conception/pregnancy is avoided by observing social customs of separation of marital partners for varying periods after the birth of baby.

**Mechanism of action:** By abstinence.

**Advantages:** Mother can devote more time to baby and regain her strength. The baby develops greater closeness to mother.

**Disadvantages:** May not be conducive to modern pattern of living. May disrupt marital relationship.

### **3.3.3. Sex without penile vaginal intercourse:**

This is practised by expression of caring and fondness of partners without penis in or near the vagina e.g. touching, hugging, masturbating.

**Mechanism of action:** Sperms never reach the vagina.



**Advantages:** No possibility of pregnancy if ejaculation does not occur in or near the vagina (e.g. between thighs). Can be practiced when there is pain, infection being treated or after surgery. Offers protection against STD and AIDS.

**Disadvantages:** Objection by one or both the partners.

#### **3.3.4. Coitus interruptus (withdrawal method):**

During sexual intercourse, erect penis is withdrawn just before ejaculation. Semen is discharged outside the vagina. It is widely practiced method all over the world, in all cultures and by people of all regions.

**Mechanism of action:** It works by depositing the sperms outside the vagina.

**Advantages:** Acceptable to many religious groups and societies, cost effective and used widely all over the world. The male partner shares responsibility for contraception. No physical side-effects are caused.

**Disadvantages:** Not suitable for those with premature ejaculation, who cannot control their build up to ejaculate and the adolescents. It does not offer protection against STD, HIV/AIDS.

#### **3.4. Condoms:**

Barrier methods of contraception especially condoms and also spermicide help preventing pregnancy.

Condom is put on the hard erect penis immediately before intercourse. It collects the semen and prevents the sperm from entering the women's vagina. About 1cm. of condom is left loose to hold the semen (condom with a teat). After ejaculation, as penis is withdrawn, the condom is held at the base of the penis to prevent it

from slipping off and spilling the semen. A new condom must be used during each act of intercourse.

Use of barrier methods of contraception or condoms also help in preventing HIV transmission. Barrier contraceptives cause virtually no health problems, yet provide protection against STD and AIDS. They also protect against some of the consequences of STD including infertility, ectopic pregnancy and cervical cancer.

#### **3.4.1. Mechanism of action:**

It prevents deposition of sperm in the vagina.

#### **3.4.2. Advantages:**

- Easily available.
- Easy to carry.
- Cheap
- Protects against STDs and AIDS.
- Ensures male participation.
- No prescription is needed.
- No systemic side-effects.
- Help men with premature ejaculation.
- Effective when used with a spermicide.
- Help in prevention of cancer cervix in female partner.

#### **3.4.3. Disadvantages:**

- Interrupts sexual intercourse as condom has to be put on an erect penis.
- Penile sensitivity sometime decreases.
- It may tear off or slip off during intercourse and can fall if not removed.
- Condom may deteriorate in too much heat or light or if stored for more than 3 years.



#### **3.4.4. Selection of condom:**

Condoms are available in large variety of sizes, thickness, colours, textures as well as in lubricated or non-lubricated forms. Warning sign that a user should know is that if he is allergic to latex or lubricants, local irritation could occur.

#### **Condom is best indicated under the following conditions:**

- Best for partners at risk of exposure to STDs and AIDS.
- As a back-up method, when pills are forgotten for more than 2 days.
- When other effective methods are contraindicated for women e.g. heart disease, liver disease, or the woman is unwilling to use other effective methods.
- Women who are breast-feeding and need contraceptive.

#### **3.5. Spermicides:**

Spermicides are available in the form of creams and foaming tablets or suppositories. "Delfen" – a cream and "Today" – a foaming tablet are available. They contain Nonoxynol-9. They can be used with condoms to increase effectiveness.

##### **3.5.1. Mechanism of action:**

Spermicides inactivate the sperms. The protection begins 10 to 15 minutes after insertion and they remain effective for about one hour.

##### **3.5.2. Indications:**

You can advise this to the women who are:

- Breast-feeding.
- Using barrier methods like condoms.
- At risk of exposure to STD including AIDS.
- Unwilling to use or have contraindications to other methods.



### **3.5.3. Advantages:**

- Easy to use
- Reversible
- No medical intervention or prescription required
- Helps protection against STDs
- No systemic effects

### **3.5.4. Disadvantages:**

- Effective for a short period-1 hour only.
- Must be used before each act of sexual intercourse.
- May interrupt sexual intercourse and needs privacy as it is to be inserted 10 minutes before the act.
- Some women may be sensitive to the spermicide and develop irritation.

### **3.5.5. Contraindications:**

- Woman or partner allergic to Nonoxynol-9.

### **3.5.6. Instructions to clients:**

- It should be inserted just before intercourse.
- If more than one hour passes the second dose will be needed.

## **3.6. Oral Contraceptive Pill:**

You should have the necessary knowledge to provide Oral Contraceptive Pill Services including counselling, appropriate screening and selection of clients, management of side-effects and offer follow-up services. There are different types of oral pills. The common ones in use under family planning welfare programme in the country is Mala-N./Mala-D. (Fig. 3.2)

### 3.6.1. What is (Mala-N/Mala-D) Oral Pill ?

- Mala -N/ Mala D is a contraceptive pill.



Fig. 3.2. Mala-N

It is an effective, safe and reversible contraceptive for women desiring to delay their first pregnancy or space the next child. Mala D/Mala-N is available in packages containing supply for one cycle. Each packet has 28 tablets; first 21 of which are white hormonal tablets and remaining are coloured iron tablets for maintaining the continuity. Mala-N is available free of cost under National Family Welfare Programme and Mala D under the Social Marketing Programme.

### 3.6.2. Advantages:

- Safe
- Reversible
- Decision with woman herself
- Non-invasive
- Privacy not required
- Other health benefits are:
  - Reduces menstrual blood loss, thus reduces chances of anaemia.
  - Relief from pain during menstruation.
  - Relief from premenstrual symptoms.
  - Regulates menstrual cycles if they are irregular.
  - Reduces chances of ectopic pregnancy.
  - Provides some protection against pelvic infection.

- Protects against benign tumours of breast and ovarian cysts.
- Reduces chances of developing cancer of uterus and ovary.

### **3.6.3. Disadvantages:**

- Need to take daily.
- No protection from STD/AIDS.

### **3.6.4. Selection of Acceptors:**

Any woman in the reproductive age group who wishes to delay the first pregnancy or wants to postpone the next pregnancy can use oral pills provided she does not have any contraindications for its use.

It is necessary to screen the acceptor for finding out her suitability for use of pills. Inform the LHV of your area about her.

### **3.6.5 Messages to be given to community:**

1. Pills are to be used regularly for avoiding pregnancy.
2. It is the optimum method to postpone first pregnancy. Pills can be used for spacing the next pregnancy especially if the woman cannot use IUD.
3. Pills can be used continuously for 5 years safely.
4. Mala-N or Mala-D tablets contain very low doses of hormones; hence these pills are safe.
5. For appropriately selected acceptors pills are safe.
6. Pills do not lead to cancer.
7. Pills have many other health benefits in addition to contraception.

### **3.6.6. Clearing myths about pills:**

To promote pill acceptance, you should remove the prevailing myths and explain the facts:



Myths	Reality
1. Pills may lead to cancer	<ul style="list-style-type: none"> <li>- Pills offer protection against cancer of ovary and endometrium.</li> <li>- No demonstrated increased risk of breast cancer.</li> </ul>
2. Pills cause infertility	<ul style="list-style-type: none"> <li>- Pills do not lead to permanent infertility.</li> <li>- After discontinuation of pills fertility returns rapidly in majority women.</li> </ul>
3. Pills harm women's health permanently	<p>Observations on millions of women have proved that there are no permanent ill effects.</p> <p>Taking pills is safer than pregnancy and childbirth.</p> <p>Pills in current use contain very low amounts of hormones; and hence do not lead to major complications.</p>
4. Baby may be deformed	Even if pills are accidentally used during undiagnosed early pregnancy, there is no increase in risk of foetal abnormalities.
5. Pills should be discontinued intermittently	<p>Pills can be safely used continuously for 5 years.</p> <p>Interruption of pills without use of other contraceptive can result in unwanted pregnancy.</p>

(Refer to Government of India's Guideline for Oral Pills)

### 3.7. Copper T:

Copper T (CuT) is an intrauterine contraceptive device. Cu T 200 B is a 'T' shaped plastic device made of polyethylene and impregnated with Barium Sulphate to make it radio-opaque. It is 3.6 cms in length and 3.2 cms in width. Copper is wound round its vertical stem. Its surface area is 200 mm and the thread is attached to the lower end of the vertical stem. Figure 3.3 shows Cu T 200 B. It is a safe and reliable method of contraception and it offers several advantages, namely

- One time insertion procedure.
- It is readily reversible.
- It is coitus independent.
- Effective for 3 years.
- It is cost effective.

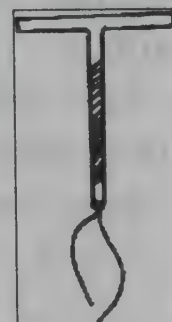


Fig. 3.3  
Copper T

Despite all these, it is disappointing to note that the continuation rate of less than 30 % at the end of one year has not improved over the years. This may be due to improper selection of cases who may develop side-effects and demand its removal. It may also be due to poor counselling and motivation by the medical and paramedical staff.

In view of this and the above-mentioned advantages it is necessary to increase the acceptability and continuation rates of this method especially for spacing of children.

#### 3.7.1 Counselling:

You should counsel the client in a simple language, which she understands and the following information should be provided to her:

- I. It is one of the most effective and reversible methods for family planning.



- II. It is ideal for spacing of children, as it does not affect the quality of milk in lactating mothers. Spacing is important for health of the mother and children.
- III. It can be easily removed when desired.
- IV. It provides continuous protection for 3 years.
- V. Its insertion is a simple procedure and the optimal time of insertion is during the last two days of the menstrual period and immediately following MTP. It can be inserted within seven to ten days after last menstrual period.
- VI. It does not affect sexual pleasure, performance nor hurts the husband.
- VII. IUD does not affect a women's chance of becoming pregnant after its removal.
- VIII. IUD does not cause cancer.
- IX. It has 1-3 % chance of failure.

(For details of counselling technique refer to Block on Communication ).

### **3.7.2. Selection of cases for IUD:**

- Any woman in the reproductive age group who wants to space or avoid pregnancy.
- It should be promoted in couples having two children when the age of the younger child is less than five years.
- Woman who has borne at least one child.
- Woman who has no history of pelvic diseases.
- Woman who has normal menstrual periods.
- Woman who is willing to check the IUD tail.
- Woman who has access to follow-up and treatment of potential problems.
- Woman who is in a monogamous relationship.

To summarize most of the women can be advised IUD safely after their first delivery. You should rule out pregnancy, abdominal pain with heavy irregular or prolonged bleeding or purulent discharge.



### 3.7.3. Contraindications:

- **Absolute**

IUD should not be inserted in the following conditions:

- Pregnancy;
- Anaemia with haemoglobin less than 8 gms;
- Excessive or irregular menstrual bleeding;
- Active genital tract infection e.g. vaginitis, cervicitis, pelvic inflammatory disease, septic abortion, cervical erosion;
- Previous history of ectopic pregnancy.

- **Relative**

- Previous history of caesarean section;
  - Medical disorders like heart disease, diabetes, etc.
- In both these conditions refer to specialists.

### 3.7.4 Sterilisation of equipment:

CuT is available in a pre-sterilised pack.

You must ensure that all instruments/gloves are preferably autoclaved. In case autoclaving is not possible you must see that the instruments are fully immersed in water and boiled for at least 20 minutes.

**In order to prevent any infection it is essential that instruments are autoclaved or fully immersed in water and boiled for at least 20 minutes after the water starts boiling.**

### 3.8 Permanent methods:

You must counsel the clients for permanent methods of sterilization and refer those who opt for permanent methods of sterilization to M.O. PHC. To the female client you can tell

about tubectomy by minilap or laparoscopy. To the male client you can tell about vasectomy by non-scalpel method or conventional.

- You must explain to the client that:
  - I. It is a safe and simple procedure.
  - II. It is a permanent procedure for preventing future pregnancies.
  - III. It is a surgical procedure that has a small risk of complications requiring further treatment.
  - IV. It does not affect sexual pleasure, ability, or performance.
  - V. It will not affect the client's ability to carry out normal day-to-day work.
  - VI. It has a small chance of failure, even if performed under optimum circumstances.
  - VII. After vasectomy it is necessary to use a back-up contraceptive method either for 20 ejaculations or for a period of three months.
  - VIII. Sterilization does not provide protection against RTI/STD or HIV/AIDS.

### **3.9 Health Education/Counselling:**

Follow the steps explained below during the client's first family planning visit or any time the client wishes to change her contraceptive methods.

The important steps to follow are summarized below:

- Greet the client, offer her a seat, make her comfortable, tell your name and ask for her name.
- Establish rapport, show concern, respect privacy and confidentiality.
- Let her get the feeling that you are there to help her.
- Ask what will happen from beginning to the end of the visit.

- Discuss all available methods so the client can make an informed choice.
- Follow procedures for the specific method chosen.

Subsequent steps, once the client has chosen any one of the method be as follows:

**STEP I** Discuss the client's past experience with the method. If she has no past experience with the method, discuss and clarify any rumors or mistaken ideas the client may have about the method.

**STEP II** Explain in details what the method is and how it works? If appropriate, a sample can be provided. She may examine it and handle it. Encourage her to ask questions or any clarification about any information you have provided.

**STEP III** Describe the advantages and disadvantages of the method both contraceptive and non-contraceptive.

**STEP IV** Explain the appropriateness of the method for the client through history and physical examination.

**After history and examination, if the method is not appropriate, inform her why the method is not appropriate for her. Help the client make an informed choice of another appropriate method.**

**STEP V** Explain the instructions to the client for use of the method. Encourage to repeat the instructions in their own words. If she has misunderstood or omitted any instruction, go over the information again with her.



**STEP VI** Plan for the return visit. Explain and schedule the next visit. Remind client about warning signals and tell them to return sooner than planned in case of presence of warning signals.

**STEP VII** Follow procedures for the return visit.

For details of counselling technique refer to Block on Communication. Ask during the follow-up visit, whether they are happy with their chosen method.

For satisfied clients, ensure that the instructions are followed correctly for the use of the method.

Remind warning signals again.  
Dispense supplies where appropriate.  
Plan for next return visit.

For dissatisfied clients, manage the side-effects as necessary or remove the method and help the client to make an informed choice of another method.

### **3.10 Monitoring/Reporting as per Format:**

To be done for Oral pills, Cu-T, and sterilization as per formats. Refer to Block on Management.

#### **Key points (Contraception) :**

- Planning requirement for contraception based on birth rate, parity and number of previous users (Condom, OCP).
- Too early, too late, too many pregnancies are cause of high maternal and neonatal morbidity and mortality rates.
- Counselling for appropriate contraceptive method is crucial for success of the programme.
- Benefits and risks of each contraceptive method should be explained to the client.

- Management of logistics and supplies for family planning.
- Danger signals to be explained to the client.
- Follow-up of the family planning acceptors is necessary.
- Reporting services provided with accuracy and completeness as per the formats.

### 3.11. Supervisory check-list

You have to supervise the record maintenance as well as counter check from the community the services provided by the HW(M). Refer to Block on Management.

Tick ✓ if applicable and X if not	A	Natural Methods
		1. Estimates the number of eligible couples. 2. Is aware of natural methods of contraception. 3. Is aware of exclusive breast-feeding. 4. Can calculate the safe period.
	B	Barrier Methods
		1. Can store condoms. 2. Knows the advantages of condoms. 3. Is aware of spermicides.
	C	Oral Contraceptive Pills
		1. Can instruct the client how to start the pills. 2. Can do the regular follow-up of women on OCs. 3. Knows how to procure the pill and store them.
	D	IUDs
		1. Can counsel the client for IUDs. 2. Knows the indications for removal.

### 3.12. Self-assessment Questions:

7. What are the advantages of Condoms ?
8. What are the advantages of Oral pills?
9. What are contraindications of IUCD?





## **UNIT 4**

### ***PREVENTION AND MANAGEMENT OF REPRODUCTIVE TRACT INFECTIONS/SEXUALLY TRANSMITTED INFECTIONS***

#### **LEARNING OBJECTIVES**

At the end of this unit, you should be able to:

- identify the individual with symptoms of RTI/STI.
- elicit and record relevant history in symptomatic individual and do appropriate referral.
- explain the importance of partner identification.
- provide counselling/health education to the individual, family and the community to prevent RTI/STI including HIV/AIDS.
- practise methods of infection control to prevent spread of infection amongst the health personnel.

#### **CONTENTS**

- 4.1. Introduction
- 4.2. Identification of the individual with symptoms of RTI/STI
- 4.3. History taking
- 4.4. Importance of partner identification and prompt referral
- 4.5. Facts and misconception regarding HIV/AIDS
- 4.6. Health education/counselling to prevent RTI/STI including HIV/AIDS
- 4.7. Methods of infection control for prevention of infection amongst health personnel and patients
- 4.8. Recording and reporting
- 4.9. Supervisory checklist
- 4.10. Self-assessment questions

#### **4.1. Introduction:**

Sexually Transmitted Infection (STI) occur following sexual intercourse with the infected person, which results in genital ulcers and discharges. The infection can affect penis ,scrotum ,inguinal lymphnodes of the man and vulva, vagina, cervix, uterus, tubes and ovaries in the woman. Untreated they can be a cause for spread of HIV/AIDS in the community. Presence of RTI/STI in any person may result in flare-up of infection following insertion of IUCD. Therefore insertion of IUCD in such patient is contraindicated. In pregnancy the foetus may be affected by these infections. They may also be a cause for development of cervical cancer.

You should know about RTI/STI since you are expected to identify the man who have these problems and to advise/counsel them and appropriately refer them to MO(PHC).

#### **4.2. Identification of the Individual with Symptoms of RTIs/STIs:**

RTI/STI is suspected in a man who seeks health care for:

- Urethral discharge
- Genital ulcers
- Enlarged and or painful inguinal lymph nodes
- Scrotal swelling
- man whose wife/sexual partner has problem of vaginal discharge with burning during urination or ulcers of genitals, or pain lower abdomen

#### **4.3 History Taking**

1. When did the discharge start?
2. Does his sexual partner have any sore on the genital organ or vaginal discharge?
3. What is the nature of discharge ?
4. Whether he has burning while passing urine?
5. Does his wife have pain in lower abdomen, which increases during menstrual period or vaginal discharge?

6. Does she have any ulcer in the genital region? (Presence of vulva (ulcers can be confirmed by looking at the vulva.)

#### **4.4. Importance of Partner Identification and Prompt Referral:**

All the STIs are transmitted from an infected partner. The treatment of the individual is not sufficient unless and until her partner is treated simultaneously. Many a time their female sexual partner may not be having any manifest symptoms like ulcers or discharges or any other complaints.

It is important that the affected sexual partner gets properly diagnosed and treated by referring him to M.O. PHC. This will prevent continuance and spread of infection in the sexual partners.

#### **4.5. Facts and Misconceptions Regarding HIV/AIDS:**

##### **HIV/AIDS Problem in India**

The growing evidence available from all over the world undoubtedly indicates that the incidence of HIV infection is higher in conditions related to STDs. India has a high incidence of STDs. 5 % of all infections are due to STDs. STDs particularly those characterized by genital ulcers increase the chance of HIV infection. Therefore a person already having STD has a greater risk of acquiring HIV from sexual intercourse if he/she comes in contact with an infected partner.

Among the probable source of HIV transmission in our country heterosexual promiscuity constitutes the major route as almost 75 % of HIV infection occur due to unprotected and multi-partner sexual contacts. It can be prevented by consistent use of good quality condoms.



### **Probable source of infection**

Heterosexuals	-	74.15%
Others	-	10.92%
Injectable drug users	-	7.3%
Homosexuals	-	0.58%
Recipients of blood	-	7.05%

(Source NACO, Country Scenario 1998-99, India)

There are three modes of HIV transmission:

1. Sexual transmission.
2. Blood transmission (Blood, blood products, infected needles or instruments).
3. Vertical transmission (Placental i.e., maternal to foetal).

***You have to dispel the following misconceptions regarding mode of transmission of HIV:***

- Mosquito bites
- Any other insects bite
- Casual contact with infected persons
- Sharing same food, water, clothes and toilets
- Professional contact (health personnel)

### **4.6 Health Education/Counselling to Prevent RTI/STI Including HIV/AIDs:**

Counselling means providing the individual with information with regard to her ailment and empowering her to make her own decisions. You should communicate to the individual the information on one to one basis, maintaining the confidentiality of the information received or given in a non-judgemental or non-moralistic manner. For more details refer to communication Module.

Health education is providing general information to the individual, family or community at large with regard to RTI/STI including HIV/AIDS.

Counselling of the individual is important in the context of preventing the spread of RTIs/STI, HIV and AIDS.

Health education/counselling on RTI/STI including HIV should provide information with regard to protective measures like:

- single mutually faithful sexual partnership.
- avoiding sexual contact if any of the sexual partners is having RTI/STI.
- correct condom usage.
- ensuring complete treatment of self and sexual partners.
- maintaining proper menstrual hygiene by use of clean pads/cloth, frequent change of the cloth.
- observing aseptic precautions during delivery/abortions and utilizing the available ante-natal and intra-natal and M.T.P. services.
- protecting your baby against the effect of RTI/STI by attending ante-natal clinic regularly.

**All cases of RTI/STI to be referred promptly to medical officer for diagnosis and treatment.**

#### **4.7 Methods of Infection Control for Prevention of Infection Amongst Health Personnel:**

If proper methods of control of infection are not practised by you while examining client and partner RTI/STI the infection can spread to you as well as other women examined by you. To avoid this, the following practices should be adopted:

- Hand washing with soap under running water for 10-15 seconds.



- Wear gloves in both hands, wash hands after removing gloves.
- Proper decontamination and disinfecting of the instruments, gloves and linen. All the things can be decontaminated by dipping in bleaching powder solution (1 Tablespoonful - 15 gms in 1 litre of water ) for 10 minutes.
- Sterilization of the instruments by autoclaving or boiling for 20 minutes.
- Wipe all the contaminated surfaces with 1.5 % bleaching solution.
- Disposal of waste material: Waste should be buried or burnt. It should never be left outside or left open in pits. For more details to refer to Unit V of this module.

#### **4.8 Recording and reporting:**

To be done for RTI/STI as per format refer to Management Module.

##### **Key Points: (RTI/STI)**

- Identify the men with RTI/STI.
- Refer the men for examination and treatment to MO PHC promptly.
- Identify sexual partners and ensure their treatment.
- Provide counselling/health education to individuals, sexual contracts, family and community.
- Observe infection prevention measures to prevent infection amongst the health personnel.



#### 4.9. Supervisory Checklist

You have to supervise the record maintenance done by HW(M) ensure timely vital registration. Refer to Block on Management.

Tick <input checked="" type="checkbox"/> if applicable and X if not	
	1. Detects the early signs and symptoms of RTI/STI.
	2. Traces partner and refers the contact for treatment.
	3. Takes adequate precautions to avoid contamination and to protect self and others .
	4. Counsels regarding prevention of RTI/STI.
	5. Explains the importance of the use of condoms to prevent RTI/STI.
	6. Explains about sexual hygiene.
	7. Explains about monogamous relationship.
	8. Refers the client to MO PHC.

#### 4.10 Self-assessment Questions:

10. What are the common symptoms in men infected with RTI/STI?
11. What are the important messages to be communicated to the individual for prevention of RTI/STI?
12. What are the modes of transmission of HIV/AIDS?



## **UNIT V**

### ***INFECTION PREVENTION***

#### **LEARNING OBJECTIVES**

At the end of this unit, you should be able to:

- define some of the commonly used terms in Infection Prevention (IP) and explain the importance of IP.
- describe the disease transmission cycle of serious diseases such as Hepatitis B and HIV/AIDS.
- discuss the fundamental principles of IP as they apply to RCH services.
- explain the importance of and correctly perform the steps of infection prevention measures and sterilization procedure for final processing of instruments and other items used.
- explain the importance and perform the correct methods of disposal of contaminated wastes.

#### **CONTENTS**

- 5.1. Introduction
- 5.2. Definitions
- 5.3. Disease transmission
- 5.4. Fundamental principles of infection prevention
- 5.5. Universal (Standard) precaution
- 5.6. Hand washing & wearing gloves
- 5.7. Use of antiseptics and disinfectants
- 5.8. Infection prevention measures and their importance
- 5.9. Supervisory check-list
- 5.10. Self-assessment questions



### 5.1. Introduction:

Prevention is better than cure and this is especially true for prevention of infection in health care set-ups. This unit of the module deals with infection prevention while rendering RCH services. The three categories of people who are at risk of infection from service delivery practices are:

- Clients/Patients
- Health Personnel
- Community Members

It is important to prevent transmission of infection at all times, including during the provision of contraceptive services, childbirth, newborn care, post-natal care, immunization, post-abortion care and management of RTIs/STIs.

### 5.2 Definitions:

- **Micro-organisms** are the causative agents of infection. They include bacteria, viruses, fungi and parasites. Bacteria can be further divided into three categories for the purpose of IP.

**Vegetative** (Staphylococcal)

**Mycobacteria** (Tuberculosis)

**Endospores** (Tetanus)

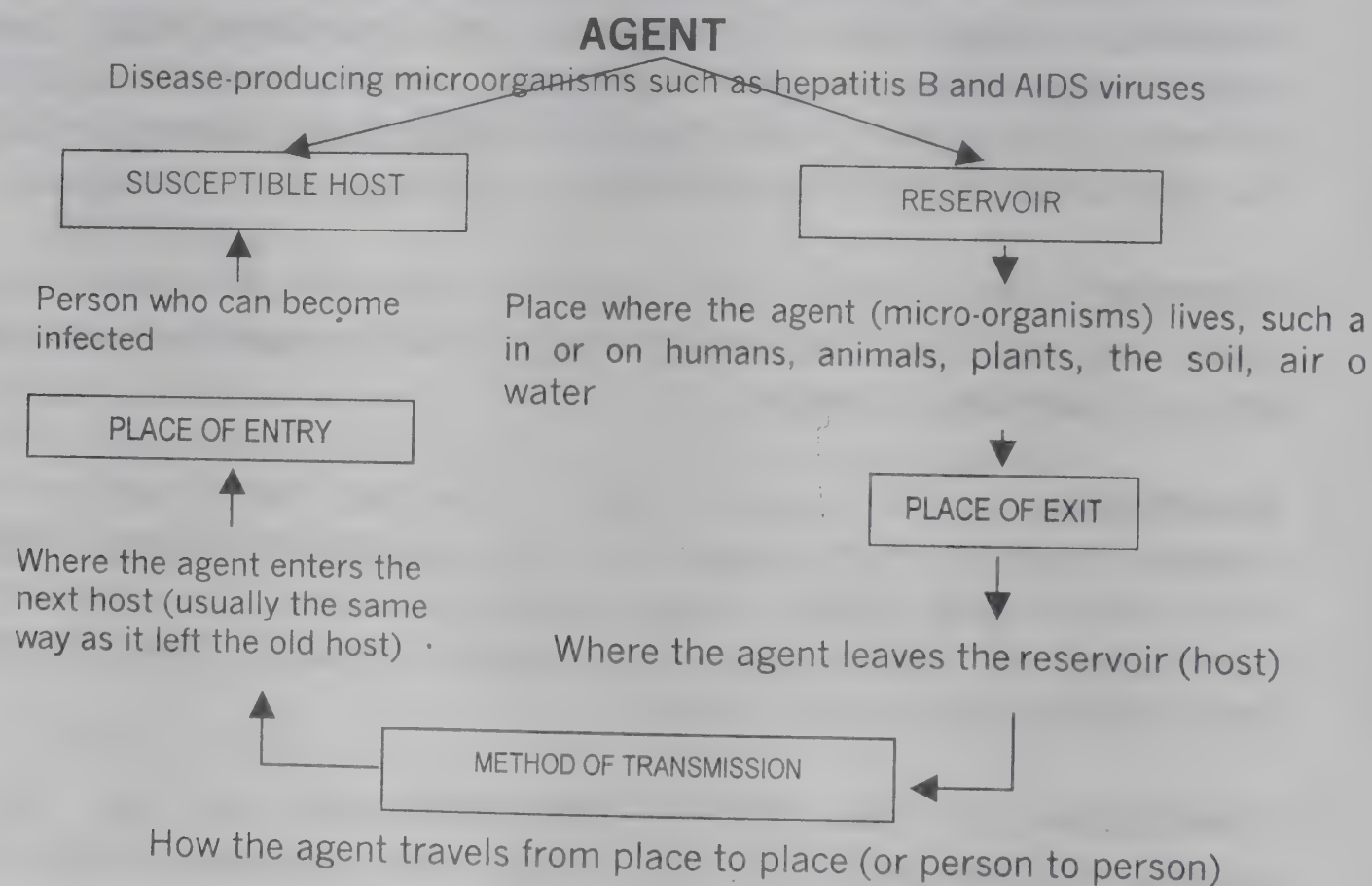
- **Protective barriers** are the barriers between the host and the micro-organisms. Protective barriers may be physical, chemical or mechanical processes which help to prevent the spread of infectious micro-organisms from clients/patients, health personnel or from health personnel to clients/patients due to lack of IP practices or from the contaminated instruments, equipment or linens etc.

- **Aseptic technique or asepsis** is the combination of efforts made to prevent the entry of micro-organisms into an area of body where they are likely to cause infection. The goal of asepsis is to reduce or eliminate the number of the micro-organisms on both animate (living) surface (skin, tissues) and inanimate objects (surgical instruments) to a safe level.
- **Antisepsis** is the prevention of infection by killing or by inhibiting the growth of micro-organisms on the skin and other body tissues.
- **Decontamination** is the process that makes inanimate objects safer to be handled by staff especially cleaning personnel before cleaning. Such objects include large surfaces e.g. pelvic examination tables, or OT tables and surgical instruments and gloves contaminated with blood or body fluids during or after surgical procedures or examination, or therapeutic procedures.
- **Cleaning** is the process that physically removes all visible blood, body fluids or any other foreign material such as dust or soil from skin or inanimate objects.
- **Disinfecting** is the process that eliminates most but not all disease causing micro-organisms from inanimate objects. High level disinfecting (HLD), through boiling or use of the chemicals, eliminates all micro-organisms except some of the bacterial endospores like tetanus spores.
- **Sterilization** is the process that eliminates all the micro-organisms (bacteria, viruses, fungi and parasites) including bacterial endospores.
- **Reservoir** is a place where the micro-organism agent lives e.g. air, soil-water, animals, plants or on humans.
- **Susceptible host** is person who can become infected.



### 5.3 Disease Transmission Cycle:

Micro-organisms live everywhere in our environment. Individuals normally carry them on their skin, respiratory, intestinal and genital tracts. These micro-organisms are known as normal flora. In addition microorganisms live in animals, soil, air, plants and water. Some organisms are more pathogenic than others, i.e. they are more likely to cause the disease. Given the right circumstances all micro-organisms may cause infection. Bacteria, viruses and other agents survive and spread within the community due to the presence of certain favourable factors or conditions. The cycle of the disease transmission from reservoir to susceptible host is illustrated in Fig. 5 1.



**Fig. 5.1 Disease Transmission Cycle**



#### **5.4. Fundamental Principles of Infection Prevention (IP):**

Everyone who works at health care facility is at risk of getting the infection. The doctors, nurses, or health workers who have direct contact with clients/patients and those who wash the instruments and other items, clean up the examination rooms, OT and dispose the contaminated waste are also at the risk of getting infection.

Diseases producing micro-organisms live in reservoir like humans, animals and plants. From there they reach the susceptible individual via skin, orofaecal route blood stream etc. You can break the disease transmission cycle by preventing the spread of infection.

Clients are at risk of infection when appropriate IP measures are not taken by the health personnel e.g. hand is not washed between clients/patients or the procedures, inadequate preparation of the client prior to clinical procedures or use of instruments or equipment which has not been appropriately disinfected.

Health personnel including you and cleaning staffs are at significant risk of infection because they are exposed daily to the potentially infectious blood and other body fluids and potentially contaminated instruments, linens and waste. Therefore appropriate infection prevention procedures can and should be adopted by every staff member of health care facility as they apply to his or her tasks. Mode of transmission is the easiest point to break in the disease transmission cycle. While providing RCH service to client this can be accomplished by:

- Hand washing.
- Aseptic techniques.
- Correct disinfection of the instruments and other items for reuse.
- Correct disposal of medical wastes.

**Make safety a habit, protect the client/patient and yourself**

Remember it is not always possible to know who is infected with HIV or Hepatitis-B which are various conditions and can lead to the death of the individual. Therefore any instrument needle, syringe or linen contaminated with body fluids or blood must be handled as though the client/patient is potentially infected. Therefore appropriate infection prevention measures must be taken to minimize transmission of infection.

**Infection prevention is the responsibility of every staff member working in the health care facility.**

### **5.5 Universal (Standard) Precautions:**

These are set of clinical practice recommendations to help to minimize the risk of exposure to infections to both clients and workers. They help to break the disease transmission cycle at the mode of transmission step. The precautions to be taken by you are:

- Wash your hands.
- Wear gloves in both hands.
- Wear gowns/plastic aprons.
- Properly disinfecting the instruments and client care equipment.
- Maintain environmental cleanliness and adopt appropriate waste disposal practices.
- Handle, transport and process soiled/used linens correctly.
- Prevent injuries with sharp instruments (puncture wounds).

### **5.6. Hand Washing, Wearing Gloves: Hand Washing**

Hand washing is the single most important infection prevention procedure. Wash your hands thoroughly with soap and water. Hand washing leads to significant reduction in number of potential infection causing organisms on your hands. It decreases client morbidity (sickness) and mortality (death) due to clinically acquired infections. (Fig. 5.2.).

**Fig. 5.2 Steps of Effective Hand Washing**



**Step 1: Wash palms and**



**Step 2: Wash back of hands**



**Step 3: Wash fingers and knuckles**



**Step 4: Wash thumbs**



**Step 5: Wash finger tips**



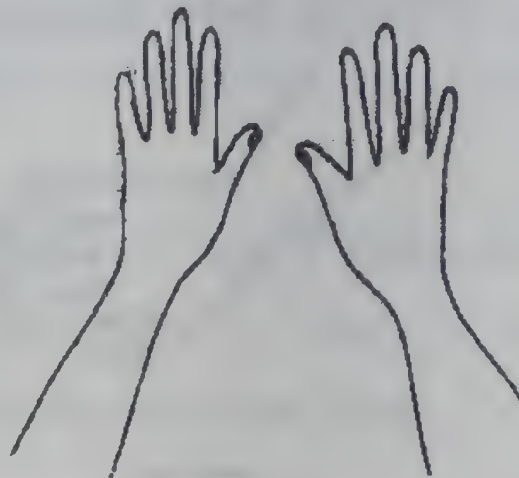
**Step 6: Wash wrists**



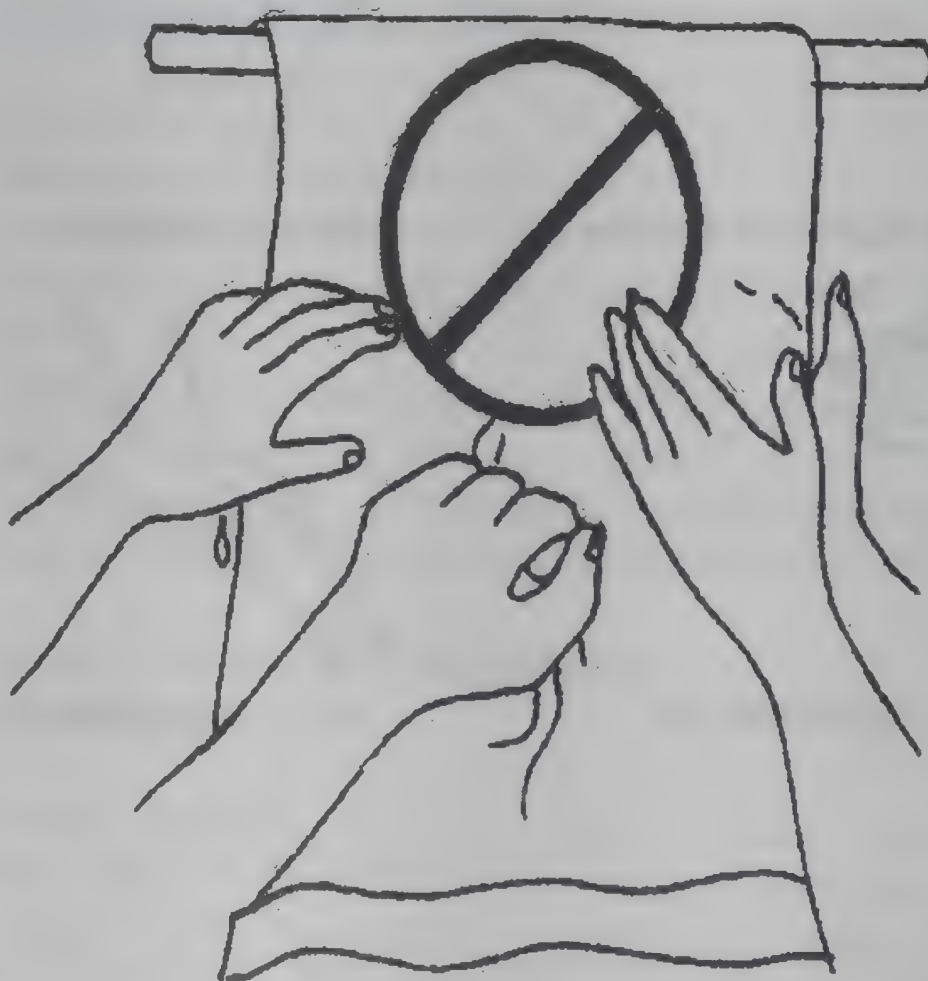
**Fig. 5-3 Hand Drying**



**Personal Towel**

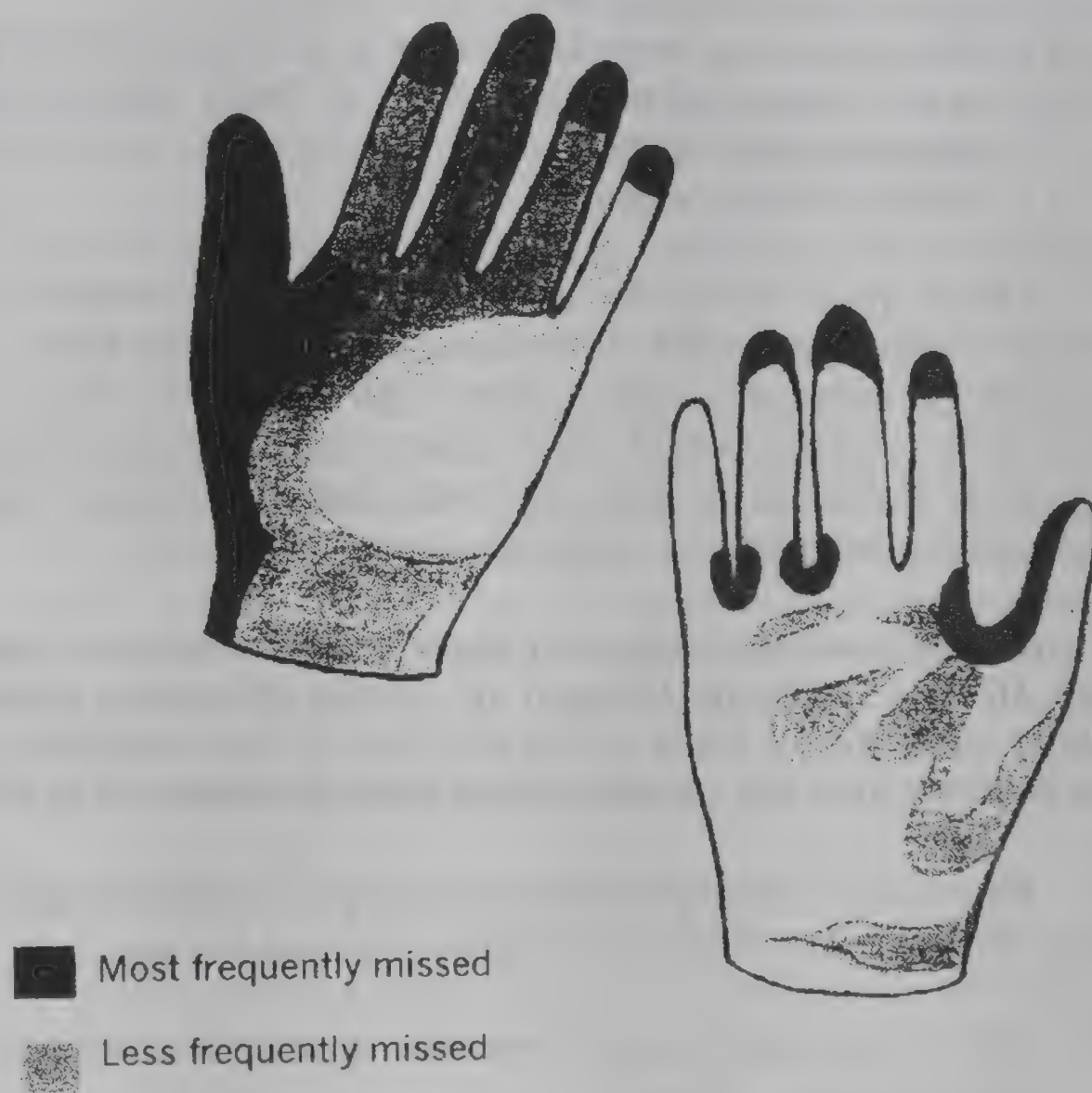


**Air Dry**



**Don't use a common towel to dry hands**

**Fig. 5.4 Areas commonly missed during handwashing**



Appropriate situations for hand washing procedures to be adopted by you are:

- Before examining the client.
- After examining the client.
- Before putting on the gloves for clinical procedures such as pelvic examination and IUD insertion.
- After touching any object that might be potentially infected e.g. contaminated with blood or body fluids or touching mucus membranes.
- After removal of gloves.

Check your hands for any cuts, sores or rashes. Cover any cuts etc. with waterproof adhesive plaster. If doubtful about the presence of cuts etc. rub a little spirit, any burning sensation confirms it. Avoid contact with blood, semen, vaginal fluid or any other body fluids on broken skin with rashes. Always wear gloves whenever you are likely to touch any body fluids.

A brief hand washing with plain or anti-microbial soap for about 10 to 15 seconds followed by rinsing in running stream of water is sufficient for most of the activities. If hand washing is not done properly then you can miss a few areas as shown in Fig. 5.4.

Micro-organisms grow and multiply in moisture and standing water; therefore you must ensure the following things:

- that if bar soap is used, provides small bars and soaps racks, which drain.
- to avoid dipping hands repeatedly into basins containing the standing water with addition of antiseptic agent, such as dettol or savlon, because micro-organisms may survive and multiply in these solutions.
- when running water is not available then use a bucket with a tap which can be turned off to lather hands and turned on again for rinsing or some body must pour water from a container for your hand washing.



- dry your hands with clean towel or air dry. Shared towels can readily be contaminated Fig. 5.3.

- **Wear Gloves**

As a precaution, gloves should be worn in both hands by all health personnel including you prior to contact with blood or any body fluids from any client. A separate pair of gloves should be used for each client to avoid cross-infection. Regarding use of gloves remember the following points:

- Do not use gloves, which are cracked, or have detectable holes or tears.
- Used gloves should be put in 0.5 % solution of chlorine for 10 minutes prior to cleaning with soap and water.
- While cleaning gloves do it inside and outside.
- Rinse in clean water until no soap remains.
- Test gloves for hole by inflating them by hand and holding under water. (Air bubbles will appear if holes are present).
- Gently air-dry the gloves inside out before proceeding with HLD or sterilisation.

## **5.7 Use of Antiseptics and Disinfectants:**

- **Antiseptics: (Savlon, Betadine, Dettol)**

Antiseptic is a chemical agent used on skin and mucous membrane to reduce the number of micro-organisms without causing damage or irritation. Antiseptics are not meant to be used on inanimate objects or surfaces as they usually do not have the same power as disinfectant to kill the micro-organisms on inanimate objects. Items such as pick-up (Cheatles) forceps, scissors, scalpel, blades and suture needles should never be left soaking in an anti-septic solution.

Antiseptics are used for:

Surgical hand scrub.

- Skin, cervical or vaginal preparation prior to clinical procedure.
- Hand washing in high-risk situations such as prior to invasive procedure or contact with a client at high-risk of infection (e.g. New-borns or immuno-suppressed clients).

- **Disinfectants**

High level disinfectants (HLD) will destroy all micro-organisms except some bacterial endospores. Objects that have undergone HLD are safe to touch intact mucus membranes or broken skin. HLD can be achieved by boiling or soaking the instruments in various chemical disinfectants.

Do not use any disinfectant on skin or mucus membranes as they can potentially damage the tissues.

- **Chlorine**

- Chlorine solutions are fast in action.
- Very effective against Hepatitis-B virus and against HIV.
- It is very cheap and readily available.
- 0.5% of chlorine solution is used for 10 minutes decontaminating surfaces and instruments before cleaning. (One table-spoonful 10-15 gms of bleaching powder in one litre of water).
- Is corrosive to metals with prolonged contact (more than 20 minutes).
- Can be irritating to the eyes, skin and to the respiratory tract.
- Should be changed daily, prepared freshly or more frequently, since the potency can be lost rapidly over time or after exposure to sunlight.



- **Boiling**

Boiling water is an effective practical way to provide HLD of gloves and instruments when sterilization cannot be done. Boiling instruments in water for 20 minutes will kill vegetative forms of bacteria, viruses (HIV/Hepatitis-B), fungi but it will not reliably kill all endospores and thus will not achieve sterilization.

- **Boiling Tips:**

- Start timing when water begins to boil.
- Always boil for 20 minutes in a vessel with a lid.
- Items must be completely immersed in water during boiling.
- Do not add anything to the vessel after boiling begins.
- Air-dry before use or storage.

**Advantages:** Boiling is an excellent, inexpensive procedure. It is easily controlled and requires no dilutions. The heat source, pan and water are commonly available.

**Disadvantages:** Boiling must be correctly performed to ensure effectiveness (i.e. timing started only after water has reached boiling point and no items are added after timing has started). Objects cannot be packed tightly during boiling to ensure proper disinfecting.

The antiseptic or disinfectants become contaminated when:

1. for dilution, the water used is contaminated.
2. the containers are contaminated.
3. when contaminated instrument or other items come in contact with the solution or the area where solution is prepared, is not clean.

Prevent contamination of the solutions by pouring it into small clean reusable container during service delivery. Always pour solution out of the container without touching rim or solution itself



with your hand or cotton gauze as these can contaminate the entire bottle of solution.

### **5.8. Infection Prevention Measures & their importance:**

- Wash hands thoroughly with soap and water.
- Wear gloves when performing a procedure in the clinic, when handling soiled instruments, gloves, or other items or when disposing off contaminated waste.
- Wear utility gloves while washing the instruments and other items. (Utility gloves are thick rubber gloves).
- Clean the client's skin properly before giving an injection. Separate syringe and needle should be used for each client.
- The reusable items must be decontaminated after use on each client. The decontamination is to be done by soaking in 0.5 % chlorine solution. After decontamination, clean well with detergent/soap and water using brush to remove any dirt or organic matter, etc. Sterilization should be done after cleaning.
- Sterilized objects should not be touched with bare hands.
- Do vaginal examination only when needed. Clean the cervix with antiseptic solution before insertion of IUD.
- Observing the principle of five cleans viz:
  1. Clean hands
  2. Clean surface
  3. Clean blade
  4. Clean cord tie
  5. Clean cord stump
- Do not use surgical spirit or alcohol for wiping spills etc. on surfaces as it evaporates too fast to kill HIV.
- Break ampoule with opener or file to avoid injury to your hands.
- Never leave the needle inserted in the rubber stopper of the vial (as this will provide direct route for entry of bacteria into the vial).

- Never pipette blood or any other body fluids by mouth.
- Do not touch your eyes or nose or other exposed skin or mucus membranes while working.
- Always carry needles or sharps in a kidney tray before and after use. (Dispose these carefully by putting them in separate labelled puncture proof container immediately after use).
- Put any waste that has been soiled by body fluids into a separate labelled and covered container.
- Always use prelabelled screw cap container for collection of samples. Wipe the external surface of the container with 0.5% chlorine solution.
- Incinerate (burn) the contaminated waste daily or bury in a pit containing bleaching powder.
- Wash hands, gloves thoroughly after disposing the wastes.
- The woman must use clean cloth or vaginal pads after delivery.
- If the practice is to bury the placenta spread bleaching powder in the pit for burial and then on the placenta. Other blood soaked items being discarded should be covered with bleaching powder.

#### **Key points: (Infection Prevention)**

- Prevention is better than cure.
- Infection can be transmitted from client to client or client to health worker or vice-versa and from health care facility to community.
- Mode of transmission is the easiest point to break in the disease transmission cycle.
- Every person working in the health care facility has the responsibility to observe I.P. measures.
- Standard precautions must be observed with every client as it is not possible to know whether the client is infected with HIV or Hepatitis-B infection.
- Antiseptics to be used only for living tissues (skin, mucus membranes). Disinfectants should not be used on skin or mucus membranes.
- Always decontaminate before cleaning, sterilization.



- Thorough hand washing with soap and clean running water is the most important step in I.P.
- Use of principle of 5 cleans is crucial for I.P. during or after delivery.
- Appropriate disposal of contaminated waste is important to prevent spread of infection in the community.

### 5.9. Supervisory checklist

You have to supervise the record maintenance as well as counter check from the community the services provided by the HW(M). Refer to Block on Management.

Tick <input type="checkbox"/> if applicable and <input type="checkbox"/> if not	√	if X	
			1. Practices methods of prevention of infections.
			2. Can enumerate the fundamental principles of infection prevention.
			3. Can discuss the correct method of hand washing and wearing gloves.
			4. Takes necessary precautions while examining, performing procedures on clients.
			5. Can use the antiseptics and disinfectants appropriately.
			6. Can make the household bleach, sodium hypochlorite and calcium hypochlorite solution.
			7. Decontaminates everything immediately after use and before clearing.
			8. Can do disposal of the waste in the correct way
			9. Sterilises gloves.
			10. Sterilises and store gauze pieces.
			11. Sterilises instruments.
			12. Disinfects labour room and labour table.
			13. Disinfects blood soaked clothes.
			14. Dispose off the placenta and blood soaked pads.

### 5.10. Self-assessment Questions:

13. How do you make chlorine solution?
14. Enumerate some of the methods of infection control for prevention of infection amongst health personnel?
15. What is the appropriate time for hand washing?



## Answers to Self-assessment Questions on Ante-natal Care

1. The leading causes of maternal mortality in India are:

- Anaemia and haemorrhage
- Infections
- Toxaemia
- Obstructed labour
- Induced abortions

2. Refer to FRU in the following situations:

- Bad obstetric history
- Bleeding during pregnancy (more than 12 weeks)
- P.I.H./Eclampsia
- Abnormal presentation
- Multiple pregnancy/over distended uterus
- Grande multipara
- Previous H/O operative delivery e.g. caesarean section difficult forceps
- Age more than 35 years
- Floating head in a primigravida at 38 weeks or later
- Pre-term labour
- Premature rupture of membranes (if labour pain does not start within 6-8 hours)
- Very big/very small baby

3. The danger signs during pregnancy are:

- Bleeding
- Breathlessness (severe anaemia)
- Convulsions, severe headache
- Swelling of face and hands
- High grade fever
- Labour pain for more than 12 hours

- 4.
- The first injection is given at the time of the first contact with the pregnant woman.
  - The second injection is given after one month. If the woman had received tetanus toxoid during a previous pregnancy less than 3 years ago, only one injection is sufficient. However, in case of doubt give 2 injections.

You must ensure that the injections must be completed at least one month before delivery. There may be slight pain at the injection site for a day or two.

5. The dangers of unsafe abortion are:
- Infections (sepsis) resulting in various life-threatening situations like peritonitis, septicemia, renal failure and death.
  - Excessive vaginal bleeding resulting in shock, and death.
  - May result in vesico-vaginal or recto-vaginal fistulae.
6. Best period for safe abortion is between 6-10 weeks of gestation.
7. The advantages of condoms are:
- Easily available.
  - Easy to carry.
  - Cheap.
  - Protects against STDs and AIDS.
  - Ensures male participation.
  - No prescription is needed.
  - No systemic side-effects.
  - Help men with premature ejaculation.
  - Effective when used with a spermicide.
  - Help in prevention of cancer cervix in female partner.

8. The advantages of oral pills are:

- Safe.
- Reversible.
- Decision with woman herself.
- Non-invasive.
- Privacy not required.
- Reduces menstrual blood loss, thus reduces chances of anaemia.
- Relief from pain during menstruation.
- Relief from pre-menstrual symptoms.
- Regulates menstrual cycles if they are irregular.
- Reduces chances of ectopic pregnancy.
- Provides some protection against pelvic infection.
- Protects against benign tumours of breast and ovarian cysts.
- Reduces chances of developing cancer of uterus and ovary.

9. The contra-indications of IUCD are absolute and relative:

**Absolute are:**

- Pregnancy.
- Anaemia with haemoglobin less than 8 gms %.
- Excessive or irregular menstrual bleeding.
- Active genital tract infection e.g. vaginitis, cervicitis, pelvic inflammatory disease, septic abortion, cervical erosion.
- Enlarged uterus.
- Previous history of ectopic pregnancy.

**Relative are:**

- Previous history of caesarean section;
- Medical disorders like heart disease, diabetes, etc.

10. The common symptoms in women infected with RTI/STI are:



- Vaginal discharge with or without itching.
- Genital ulcers.
- Lower abdominal pain.
- Backache.
- Woman whose husband/sexual partner has problem of urethral discharge with burning during urination or ulcers of genitals, scrotal swelling or inguinal buboes.

11. The following messages to be given:

- single mutually faithful sexual partnership.
- avoiding sexual contact if any of the sexual partners is having RTI/STI.
- correct condom usage.
- ensuring complete treatment of self and sexual partners.
- maintaining proper menstrual hygiene by use of clean pads/cloth, frequent change of the cloth.
- observing aseptic precautions during delivery/abortions and utilizing the available ante-natal and intra-natal and M.T.P. services.
- protecting your baby against the effect of RTI/STI by attending ante-natal clinic regularly.
- All cases of RTI/STI to be referred promptly to medical officer for diagnosis and treatment.

12. There are three modes of HIV transmission:

1. Sexual transmission.
2. Blood transmission (Blood, blood products, infected needles or instruments).
3. Vertical transmission (Placental i.e., maternal to foetal).

13. Chlorine solution is made by adding one table spoonful 10-15 gms of bleaching powder in one litre of water.

14. Methods for preventing infection amongst health personnel are:

- Proper decontamination and disinfecting of the instruments, gloves and linen. All the things can be decontaminated by dipping in bleaching power solution (1 Table spoonful - 15 gms in 1 litre of water ) for 10 minutes.
- Sterilization of the instruments by autoclaving or boiling for 20 minutes.
- Wipe all the contaminated surfaces with 1.5 % bleaching solution.
- Disposal of waste material: Waste should be buried or burnt. It should never be left outside or left open in pits.

15. Appropriate time for hand washing is:

- Before examining the client.
- After examining the client.
- Before putting on the gloves for clinical procedures such as pelvic examination and IUD insertion.
- After touching any object that might be potentially infected e.g. contaminated with blood or body fluids or touching mucus membranes.
- After removal of gloves.
- Wear gloves in both hands, wash hands after removing gloves.





# Child Health

for

## *Health Assistant (Male)*





## **UNIT - 1**

### ***IMMUNIZATION***

#### **LEARNING OBJECTIVES**

*At the end of this unit you should be able to:*

- ◆ List diseases that are preventable by immunization under national program.
- ◆ Identify vaccines administered in the National Program, the age at which they are given, the number of doses and the schedule to be followed.
- ◆ Demonstrate how to maintain the cold chain.
- ◆ Demonstrate methods for Sterilization of syringes and needles
- ◆ Demonstrate how to conduct immunization session.
- ◆ Demonstrate methods of administration of various vaccines.
- ◆ List ways of monitoring coverage of immunization and identify drop outs.
- ◆ Describe Surveillance including AFP.
- ◆ Identify methods to eliminate neonatal tetanus.
- ◆ Identify methods to control measles.
- ◆ Identify normal events and adverse reactions after immunization and action to be taken.
- ◆ Educate the people in the community about the importance of immunization.



## **CONTENTS:**

- 1.1 Introduction.
- 1.2 Common diseases prevented by vaccinations
- 1.3 National immunization schedule
- 1.4 Methods of administration of vaccines
- 1.5 Maintenance of the Cold Chain
- 1.6 Injection safety
- 1.7 Planning and conducting Immunization session.
- 1.8 Monitoring coverage – with the help of the map of your sub-centre area and identification of drop outs.
- 1.9 Disease Surveillance including Acute Flaccid Paralysis
- 1.10 Elimination of Neonatal Tetanus
- 1.11 Reduction of Measles
- 1.12 Adverse reaction and their management.
- 1.13 Social mobilization.

### **1.1 INTRODUCTION**

Immunization is one of the most well known and cost effective methods of preventing diseases. You administer vaccine to all infants and children in collaboration with health worker female.

### **1.2 THE COMMON VACCINE PREVENTABLE DISEASES ARE :**

Tetanus  
Poliomyelitis  
Diphtheria  
Pertussis (Whooping Cough)  
Measles and  
Childhood tuberculosis.

### **1.3 NATIONAL IMMUNIZATION SCHEDULE:**

The vaccines must be given at the right age, right dose and the full course must be completed to give the best possible

protection to the child. The schedule that tells us when and how many doses of each vaccine are to be given is called Immunization Schedule. The schedule we follow in India asks us to give two doses of **TT** to pregnant women, three doses each of **OPV** and **DPT** and one dose each of **BCG** and **Measles to the infants**.

The salient aspects are summarized in the table given below.

### National Immunization Schedule

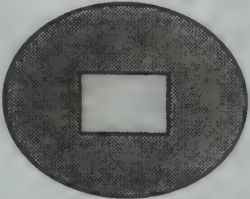
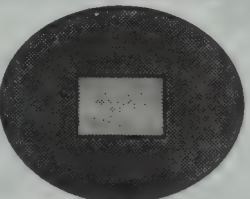
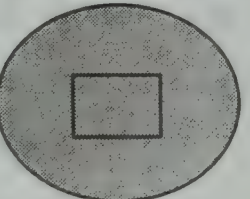
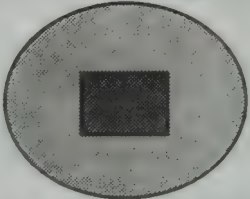
TO WHOM	WHEN	VACCINE	No. of Doses	ROUTE
Women	Pregnancy	TT	2 ( one in early pregnancy and other one month after)	Intra-muscular
Infants	At birth For Institutional deliveries	BCG	1	Intra-dermal
		Polio	'0' dose	Oral
	6 weeks	DPT	1 <sup>st</sup>	Intra-muscular
		OPV	1 <sup>st</sup>	Oral
		BCG (if not given at birth)	1	Intra-dermal
	At 10 weeks	DPT	2 <sup>nd</sup>	Intra-muscular
		OPV	2 <sup>nd</sup>	Oral
	At 14 weeks	DPT	3 <sup>rd</sup>	Intra-muscular
		OPV	3 <sup>rd</sup>	Oral
	At 9 months	Measles	1	Subcutaneous
		Vit. A prophylaxis	1 <sup>st</sup>	Oral
	At 16-24 months	DPT	1 (1 <sup>st</sup> booster)	Intra-muscular
		Vit. A Prophylaxis	2 <sup>nd</sup>	Oral
		OPV	1 (1 <sup>st</sup> booster)	Oral

<b>Children</b>	<b>5 - 6 years</b> The 2 <sup>nd</sup> dose of DT should be given at an interval of one month if there is no clear history or documental evidence of previous immunization with DPT	<b>DT</b>	<b>2<sup>nd</sup> (booster)</b>	<b>Intra-muscular</b>
	<b>10 years and 16 years</b> The 2 <sup>nd</sup> dose of TT vaccine should be given at an interval of one month if there is no clear history or documental evidence of previous immunization with DPT, DT and TT vaccine	<b>TT</b>	<b>2<sup>nd</sup></b>	<b>Intra-muscular</b>

- ◆ The dose of all vaccines is 0.5 ml except for BCG, which is 0.1 ml.
- ◆ Check the label of the vial before use.
- ◆ Interval between the doses should not be less than one month.
- ◆ Polio vaccine is given orally (two drops). Check the label of the vial for VVM and expiry date before use.



## How to read VVM ?

<b>Vaccine Vial Monitor (VVM)</b>	
	<p>If the square is lighter than the circle. If the Expiry date is not passed <b>USE the vaccine.</b></p>
	<p>If the square is dark but lighter than the circle. If the expiry date is not passed. <b>USE the vaccine</b></p>
	<p><b>The square matches the circle</b> <b>DO NOT USE the vaccine</b> <i>Inform your Supervisor.</i></p>
	<p><b>The Square is darker than the circle</b> <b>DO NOT USE the vaccine</b> <i>Inform your Supervisor</i></p>

**Fig. 1**

Other important points to note during use of OPV Fig. 1

- Use vaccines within the expiry date only even if the VVM square is still light than the outer circle.
- OPV with darker VVM (but still lighter than the outer circle) should be used in priority before other vials and within expiry date.
- Read the color of the VVM before and during use of the OPV.

## 1.4 ADMINISTRATION OF INJECTIONS

Most of the vaccines are administered by injections and depending on the nature of the vaccine, they may be given by:

- Intramuscular (deep in the muscle) for DPT, DT and TT.
- Subcutaneous (in the fatty layer under the skin) for MEASLES
- Intradermal (in to the top layers of the skin) for BCG

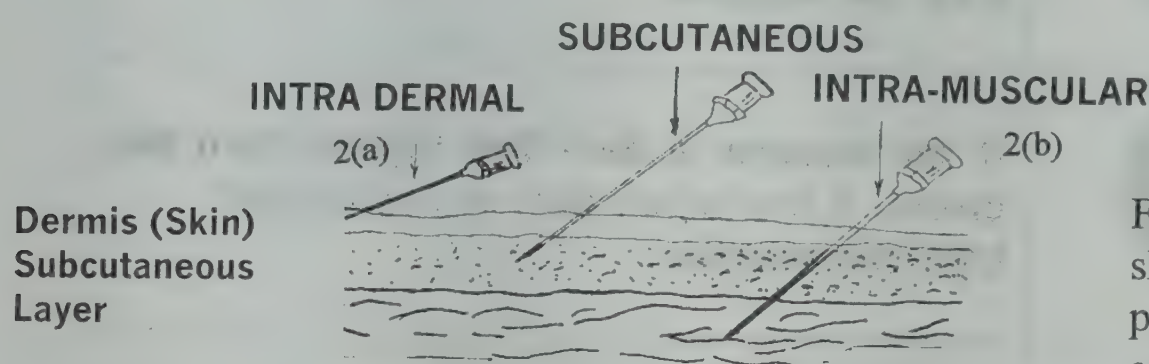


Figure Diagram showing different position of needle e.g. 2(a) & 2(b)



Fig. 2(a)

Fig. 2(b)

### Demonstrating the method of injections administration

#### 1.4.1 *Intra-muscular injection*

The best place to administer injections in infants and young children is the antero-lateral (outer) part of the mid-thigh. For much older children and adults choose the outer aspect of the upper arm **Do not inject into the buttocks.** Clean the site with spirit swab. Let the spirit dry before injecting. This helps in sterilizing the skin and less painful for the child. Place your left thumb and index finger on



either side of the injection site and stretch the skin. Hold the syringe with your right hand and plunge the needle straight down through the skin deep into the muscle (Fig.2(b)).

Withdraw the plunger / piston of the syringe slightly, to check that the tip of the needle is not in the vein in which case some blood will come into the syringe. In such case, take out the needle, maintain pressure with the swab to prevent bleeding, reassure the mother, change the needle and try at another site on the same limb or on the opposite side. DPT, DT and TT are administered by this route.

#### **1.4.2      *Subcutaneous Injection***

The measles vaccine can be administered by this route. The site chosen is usually the upper arm.

Prepare the vaccine and clean the local part as noted in the above section.

Pinch the skin between your index finger and thumb.

Push the needle into the pinched skin in a sloping manner, not straight in. Do not push in the needle too far in. Support the adapter end of the needle with your thumb and index finger.

The rest of the procedure and precautions to be taken are similar to intra-muscular injections.

#### **1.4.3      *Intra-dermal Injection***

Hold the infant's **left** arm with your left hand so that your hand is under the baby's arm your thumb and fingers come around to the front and stretch the skin (Fig. 2(a))

Hold the syringe in your right hand with the bevel and the number scale pointing up towards you.



Keep the syringe and needle almost flat on the baby's arm and insert the tip of the needle – only, the bevel and just a little bit more. Take care to keep the needle flat along the skin so that the tip of the needle goes only through the superficial layers of the skin, it remains **intra-dermal** and not subcutaneous.

Then place your left thumb over the upper end of the syringe to hold the needle in position. Support the plunger end of the syringe between the right index and middle fingers and push the plunger in slowly with the right thumb so that 0.1 ml. or volume equivalent to 10 small divisions are injected in.

If the needle is intra-dermal, a translucent superficial flat-topped swelling will appear over the tip of the needle and there will be a significant resistance in pushing the fluid inside.

In fact you have to push the plunger in harder than for intra-muscular and subcutaneous injections. For this reason, you also have to ensure that the adapter of the needle is firmly fixed on the syringe so that no leakage occurs. If the tip of the needle has gone subcutaneous inadvertently, the fluid will actually go in more easily. In such cases do the following.

Stop injecting and try and correct the position of the needle

Inject the rest of the calculated amount of the vaccine but no more, and do not repeat the injection.

**BCG is a vaccine, which is given by this route.**

Special syringes and needles are required as the volume of vaccine to be given is very small and the needle too has to be very fine so that it can be introduced very superficially.

The syringe is very narrow. Very often such syringes have two scales, one with units for insulin doses and one with “ ml.” - as .10, .20. .30., .40., .50., .60., .70., .80., .90., and 1.00 ml. Thus 0.1 ml.

of the vaccine will be equivalent to 10 tiny divisions. Do not use the scale on the other side.

## 1.5 MAINTENANCE OF COLD CHAIN

### *WHAT IS THE COLD CHAIN?*

The cold chain includes a series of items, which maintain the vaccine between 2° - 8 °C Celsius right from the time of procurement from the manufacturer to the point when it is injected into the child. It also includes persons who monitor and ensure that the temperature is maintained.

#### *1.5.1 Vaccine carriers*

The carriers are containers with thick walls and lids made of a special material, which do not allow the heat to pass through it easily. Hence they can keep vaccines that are **already** cold, maintain their low temperature for a short time.

They are used to carry vaccines from the center to the places where the children can be immunized.

Use **frozen** ice packs to keep the vaccines cold in the carrier.

These carriers **cannot make vaccines cold**. Only the refrigerators can do this.

- ◆ **Do not** leave the lid open.
- ◆ **Do not** expose the carriers to the sun.
- ◆ **Do not** sit on them. Keep them clean and dry.

*Vaccines are usually kept in the carrier for one working day.*

Vaccines can, however, be kept in the carrier for 48 hrs if the lid is kept tightly closed, all ice packs and cubes are left inside, the carrier is in the shade and away from the heat and the ice packs have not melted fully.



At the immunization site, keep opened vials in a cup of ice or on an ice pack during use.

- Any opened vial used in outreach sessions in the field areas must be discarded.
  - Unopened vials of OPV which have continuously remained in the vaccine carrier and returned from the field visits should be used immediately in the next session.

## 1.6 INJECTION SAFETY

There is every chance of increased adverse reaction and failure of the credibility of the programme if the needles and syringes are not properly sterilized. **There is additional danger of transmission of HIV/AIDS.** You assist the health worker female in sterilizing the syringes needles and other equipments before immunization to avoid failure of the credibility of this programme.

### 1.6.1 *Syringes and needles and their sterilization*

- Use autoclaved or properly sterilized separate needle and syringe for each injection. Every subcenter has been provided with a portable steam sterilize autoclave for autoclaving needles and syringes.
- Sterilization can also be done by boiling as well.

#### 1.6.1.1 Syringes and Needles for Immunization session

2 sizes of syringes and needles are generally required, viz.:

1. 2 ml. syringe with 23 gauge needle for intra-muscular and subcutaneous injections
2. Tuberculin syringe with 26 gauge needle for intra-dermal injections (BCG)



## **1.6.2 Sterilization**

Sterile means absence of germs (bacteria and viruses).

- Clean and sterilize items in the health center before start the immunization session.
- Washing removes the many of the bacteria- but some always remain.
- The needles, syringes, containers, and dishes that you use must be sterilized before you use them
- **To make your immunization instruments sterile, you must autoclave or boil them for 20 minutes in water after it starts boiling . Do not use antiseptic solutions.**
- You must use separate sterilized syringe and needle for each injection.
- Do not touch any thing after you have washed your hands.
- Keep instruments in a sterile covered container
- Use sterile forceps to pick up instruments
- Do not put your hand into the container of instruments otherwise you will contaminate them all.

### **1.6.2.1 There are three methods of Sterilization:**

#### **Autoclaving**

(Electric or non-electric)

### **1.6.2.2 Portable steam Sterilizer**

Take the rack out on a table.

Place the larger syringes in larger holes and smallest syringes in smaller holes.

Place barrel and plunger separately.

Put the rack lid on the rack and squeeze the clip on the lid so that it fits into the hole in the rack.

There is a mark inside the sterilizer base. Fill water up to this mark. If you have hard water in your centre, use boiled water.

Lift the rack by clip in the rack lid. These will be required to reassemble the syringes in immunization session.

Put the sterilize lid on the sterilizer base, press down on the top handles of the lid and turn it clockwise to close the sterilizer.

Check that safety valve is closed.

Sterilizer lid has a pressure valve too. Before you start sterilizing, close the pressure valve by pushing the lever down.

Place the sterilizer on a stove. After sometime, steam starts coming out of pressure valve. Count 5 minutes from this point and then reduce the flame. Keep it for 15 minutes. Lift the sterilizer from the stove and place it on a firm place.

Release the steam by lifting up pressure valve.

Takes long time to cool down. So sterilize your equipment well in advance of the session.

### 1.6.2.3 Boiling

Only if autoclaving or pressure sterilization are not possible should syringes and needles be boiled. Place clean gauze in a suitable size container and place the syringes and needles on this. Place the forceps upright leaning against the wall of the container making sure that the latter is not so big that the forceps fall flat into the pan. If that happens, while you try to take out the forceps your fingers will touch the water and contaminate it and the sterilized syringes.

Cover the container with a lid. Check the boiling time by seeing the clock. Count the time only **after** the boiling actually starts. At this stage, the setting in gas/ stove can be “decreased” but should be kept in such a manner that the water **continues to boil for the full 20 min.** Do not add any item into the pan **after** boiling starts. After boiling drain off all the water. Use the syringes and needles only when they cool down. Always keep the lid of the container closed when not taking out the syringe.



- Use a fresh syringe and a needle for every child
- Use Sterilized Syringes and Needles

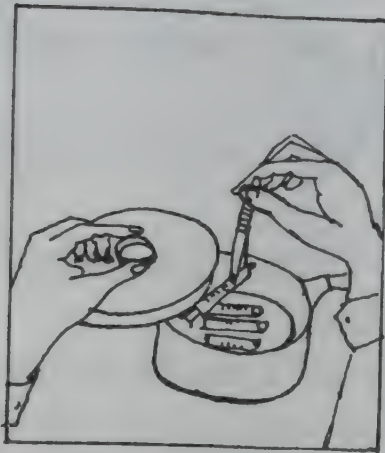


Fig. 3

Use forceps to pickup a barrel, and put it in your other hand



Fig. 4

Use forceps to pick up a plunger and needle and put it in the barrel

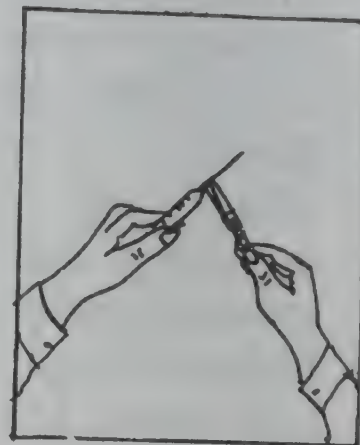


Fig. 5

Hold the needle by its adapter, fix it to the adapter of the syringe

**Be careful about not to touch the adapter of the barrel, the seal of the plunger, the shaft or bevel of the needle**

### **1.6.3 Take care to prevent injuries when:**

- ◆ Using needles to give immunizations.
- ◆ Handling needles after giving immunization.
- ◆ Cleaning needles and loading the sterilizer

## **1.7 PLANNING AND CONDUCTING IMMUNIZATION SESSION**

You have to assist health worker female in planning and conducting Immunization session efficiently as follows.

- ◆ Calculate from general statistics the expected number of children so that you can keep the necessary number of doses of the different vaccines. Keep a list of eligible families to ensure that they are all covered.



- ◆ The day and the time for immunization session in the center should be fixed and clearly displayed/informed to the community so that everyone is aware of it.
- ◆ Motivate mothers and other relations to bring their babies at the appropriate ages for the vaccines.
- ◆ Maintain a proper immunization card for each eligible infant/child.
- ◆ In case a child is brought late for a dose, pick up where the schedule was left off. Do not start it all over again.
- ◆ Some children may have minor problems after DPT such as fever, local pain, and some rash after Measles vaccine. Counsel the mother.
- ◆ Malnutrition and common minor ailments such as mild fever, cough and cold and diarrhoea are not a contraindication for immunization. In fact, take opportunity of every visit of the baby to the center to administer a vaccine taking care to ensure that there is a gap of one month between the doses of vaccines.
- ◆ Tell the mother what vaccine you are giving or what disease you are trying to prevent so that gradually the mother can try to learn. Remind her at the end when to return with the baby for the next dose.
- ◆ Immunization given must be recorded on the immunization card and immunization register. Tell the mother for keeping this card carefully and bringing it at every visit.
- ◆ If the child failed to come in time, give the next when ever possible without starting all over again.
- ◆ Remind and console the mother / family member to come to the next immunization session. (Fig. 6)

## REMEMBER

**Malnutrition, low grade fever, mild respiratory diseases, diarrhoea, and other minor illnesses are not a contraindication to immunization**

**Vaccines are effective only if full course of a potent vaccine is given at the right age.**

- ◆ It is essential to have a rough idea of the number of vaccines required for the session so that sufficient numbers can be brought. Use a ready reckoner for this purpose. (given below)



Fig. 6  
Consoling the family members

### 1.7.1 Monthly vaccine requirements (a ready reckoner)

*Estimate the number of vaccine vials required.*

#### MONTHLY VACCINE REQUIREMENTS (A READY RECKONER)

Sl. No	Popu-lation	Com-munity	Estimated Beneficiaries Monthly		MONTHLY VACCINE REQUIREMENTS				
			Preg.	Infants	DPT (Vials)	OPV (Vials)	BCG (Amp oules)	Measles (Vials)	T.T. (Vials)
1.	1000	Village / Ward	3	3	2	1	1	1	1
2.	2000	-do-	7	6	3	2	1	1	2
3.	3000	-do-	10	9	4	3	1	2	3
4.	4000	-do-	14	12	5	3	1	2	3
5.	5000	-do-	17	15	7	4	1	2	4



## **1.8 MONITORING THE VACCINE COVERAGE:**

You are already keeping records of your activities under the RCH programme and maintaining village-wise mother and infant immunization card, mother and child care records or register as well as the daily diary.

Based on these records, you make a monthly report and submit to your sectoral supervisor and finally at the PHC. Reports of all sub-centre areas are consolidated together with information from PHC itself. Reports from all PHCs in a district make a district report. In your monthly report, you also add information on diseases and deaths based on the information you collect with the help of informants in village covered by your sub-centre.

### ***1.8.1 Drop outs***

You should be keen to ensure that every pregnant woman that you register, continues with all services beginning with the 2 doses of TT. Her child should receive the complete dose of immunization against all vaccine preventable diseases covered under the programme. He should receive the 1<sup>st</sup> dose of vitamin A concentrated solution with the measles vaccine at the age of 9 months. The next dose of vitamin A and the booster doses of DPT and OPV should be given at 16 months. Thereafter the child should receive one dose of vitamin A at six monthly intervals till the age of 3 years.

So far, you were interested that there were no drop-outs from those who received the first dose of DPT till the third dose of DPT; or from the first dose of OPV till the third dose of OPV. Identify the children who were due for 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> doses and 1<sup>st</sup> booster dose of DPT and Polio from the register. Compare with the recording at the end of the clinic. Identify the children who were not brought. Follow up these children so that they can be immunized in the next immunization clinic. Now under the RCH programme, you are interested to track every pregnant woman beneficiary till her child completes the age of 3 years. Thus, in addition to determining the



drop-out between DPT 1 and DPT 3 or OPV 1 and OPV 3, you should be determining the drop-out between the first dose of immunization i.e. BCG and the last dose of immunization (to an infant) i.e. measles. You will also be interested in determining the drop-out between the 2<sup>nd</sup> dose of TT in a pregnant woman to the 5<sup>th</sup> dose of the vitamin A. Thus the child should have received 1 dose each of BCG and measles vaccines, 3 doses each of DPT and OPV as a part of primary immunization; then 1 dose of DPT and OPV as booster and 5 doses of vitamin A.

Once you started tracking down drop outs in the manner explained above, you link it with service delivery. The children who have not availed of all the doses of immunization or vitamin A will be the ones whose houses you should be visiting on a 'priority basis' during your home visits.

### ***1.8.2 Reasons for partial coverage***

**These may be due to:**

#### **1.8.2.1 Lack of Information**

- About the severity of the diseases or the complications;
- That these diseases/complications can be prevented;
- That the services are available in their areas;
- Time and place of services;
- Who should receive what services at what time.

#### **1.8.2.2 Lack of Motivation**

- No faith in immunization or other services;
- Belief in traditional methods;
- False rumours;
- Poor services and or discourteous behaviour of staff;
- Fear of side reactions.

### 1.8.2.3 Obstacles

- Immunization/ MCH session site too far;
- Time not convenient;
- Inconvenient or expensive to travel to the centre/site.

### 1.8.3 *What to do when there is poor response?*

Since the reasons may differ from place to place, these must be looked into if there is a poor response from the public. It has generally been found that this is either due to lack of information or the time and place not being convenient.

Courteous and efficient services will encourage community participation.

The immunization programme should be monitored to see that there are no reactions due to improper sterilization of syringes and needles or wrong techniques of administration of vaccines. The quality of services will speak for your concern and dedication among the families.

## 1.9 SURVEILLANCE

The number of cases and deaths of each vaccine preventable disease should be recorded. The information should be listed in a **register (LINE LISTING)** and contain the following information:

- Name
- Name of father or mother
- Age
- Sex
- Date of onset of symptoms
- Date of examination
- Date of reporting
- Immunization status
- FULL Address

- Diagnosis
- Outcome

Line listing is necessary to check for duplications in reported cases, assess immunization status, spot map areas of high risk and to make decisions on follow-up action to be taken (this will depend on the period between onset of symptoms and the receipt of the report). Follow-up visits are often necessary to confirm diagnosis, especially of poliomyelitis. Full address is necessary to trace children.

### **1.9.1      *Recognize the disease correctly***

It is important that what you mean by a case of a disease is the same as that of other health workers as well as what the village informant understands and reports as a case. Given below are the lay definitions you would use to recognize the suspect cases.

<b>DISEASE</b>	<b>LAY DEFINATION (SUSPECTED)</b>
Measles	History of fever and rash and any one of the following: Cough Running nose Red eye
A.F.P Acute                      Flaccid Paralysis	History of sudden onset of weakness and paralysis of the leg(S), and/or arm(s) and / or trunk AND history that paralysis was not present at birth or associated with serious injury or mental retardation.
Diphtheria	Sore throat, with Grey patch or patches in the throat
Neonatal Tetanus	History of normal suck and cry first two days of life and History of onset of illness between 3 and 28 days of life and History of inability to suck followed by stiffness and /or jerking of muscles.
Tetanus	History of injury or ear infection followed by difficulty in opening of mouth (or jerking of mouth) or stiffness of the neck, body.
Tuberculosis	An ill child with history of contact with a suspect or confirmed case of pulmonary tuberculosis



	Any ill child with one of the following: <ul style="list-style-type: none"> <li>• Who does not return to normal health after measles or whooping cough; and</li> <li>• With loss of weight, cough and wheeze who does not respond to antibiotic therapy for acute respiratory infection.</li> </ul>
Pertussis	History or observation of repeated and violent coughing, with any one of the following : cough persisting for two or more weeks, fits of coughing, cough followed by vomit, typical whoop in older infants.

### ***1.9.2 Surveillance of cases of acute flaccid paralysis (AFP)***

- The success of the polio eradication program is best judged not by the number of doses administered or vaccine coverage but by surveillance.
- You should keep constant watch and report every new case with acute flaccid paralysis (AFP) (locally known as "Lakwa") in children less than 15 years of age. Some of these may be due to other viruses but the polio virus constitutes the main bulk.
- Recording new cases.
- Reporting cases of AFP: Report all cases of AFP to your Medical officer immediately. AFP of non-polio etiology are expected annually i.e. 1 case per 100,000 children under 15 years of age.
- Reporting of cases should be mandatory. A NIL report should be sent monthly if no cases are seen.
- The public, local practitioners, area leaders, etc. should be motivated to report cases of acute onset of paralysis of any limb.
- All the hospital, dispensaries and clinics are to be covered for the reporting of a case of AFP.
- Concept to be given for reporting any case of AFP rather than a case of Poliomyelitis.
- Even if there is no case of AFP, then Zero case reporting must be done.

- Community must be educated about the importance of reporting a case of AFP.
- Local term for AFP like Lakwa any other term must be told to the community members.

## 1.10 ELIMINATION OF NEONATAL TETANUS

You have important role to play in national programme, of elimination of neonatal tetanus such as:

- ◆ Follow the rules of the 5 cleans.
- ◆ Educate and motivate community, women and the traditional birth attendants (**TBAs**) on **5** cleans.
- ◆ All deaths including neonatal deaths should be reported immediately to the medical officer who can then investigate the likely causes and take necessary steps to prevent its recurrence. **Neonatal tetanus** can be suspected by a history of frequent short episodes of the baby stiffening his/her body and arching the back and extending the neck. Initially, the body relaxes in between but soon tends to remain stiff. It is usually not difficult to differentiate it from fits. Even if in doubt, do report it to the doctor.

Take up all the recent deaths in the discussion with women Groups, Mahila Mandals etc. and encourage the group to identify how such deaths can be prevented.



Fig. 7 Tetanus Patient

- ◆ Immunize all pregnant women. If the woman has never had a dose of T.T give her two doses in the first pregnancy at four



weeks gap or in the pregnancy that you come in contact with her. In the subsequent pregnancy within 3 years repeat one dose.

- ◆ Counsel the community members including Panchayat and Mahila Samity members to ensure that only trained persons conduct all deliveries.

## 1.11 REDUCTION OF MEASLES

Measles is a serious disease and is associated with a large number of problems and a high mortality. The measles vaccine can effectively prevent the disease.

### 1.11.1 *Myths Associated with Measles*

There are many community beliefs, which are associated with measles, which actually interfere with the management and prevention.

Myth	Fact
1. Measles is not serious	1. Measles can cause serious problems, (especially in severely malnourished) the worst being brain damage & death.
3. It is better to get the natural disease.	2. As it can be serious, it should be prevented by use of the vaccine.
3. It is due to visitation by goddess "Mata".	3. It is due to a germ. God can never plan to harm his children.
4. Children get measles every year even after vaccination.	4. The vaccine is very safe & effective, but there are other viruses which can cause fever with red rash. They are usually much milder.



### **1.11.2      *Measles Vaccination:***

The vaccine should be given to all children between the ages of 9 - 12 months, preferably as soon as the infant completes 9 months. It can also be given to any older child if not already protected.

It is a part of the National Immunization Program. However, it is also useful to organize special mass immunization programs in the community especially just before the onset of summer, e.g. some time in March. Plan such camps once in every three months to supplement the routine immunization program.

#### **Vaccination:**

- ◆ Do not withhold the vaccine in cases of minor illness such as coughs, cold or diarrhea.
- ◆ At the time of giving the last dose (3<sup>rd</sup> dose) of DPT and OPV at that weeks, tell the mother to bring the infant to the center for the measles vaccine when the child completes 9 months (270 days).
- ◆ Give Vit. A Prophylaxis along with measles immunization.
- ◆ Increase public awareness of the risk of the disease and the efficacy of the vaccine. Talk to other village level workers like , VHG, AWW, TBA, MSS members etc.area leaders, school teachers, etc. to help to motivate the public.

**Measles is a serious illness in children. Every child needs one dose of Measles vaccine after completing the age of 9 months. Give it.**

**Give Vit. A prophylaxis along with Measles Vaccination**

*Now let us briefly review the immunization activities at various levels.*

<b>Village</b>	<p>Enumeration for immunization.</p> <p>Ensuring timely completion of immunization schedule.</p> <p>Maintenance of immunization cards.</p> <p>Motivate other eligible beneficiaries.</p>
Mother with assistance of VHGA/AAW/TBA	<p>Education of mother on:</p> <ul style="list-style-type: none"> <li>– Need for immunization.</li> <li>– Completion of all doses of immunization as per schedule.</li> <li>– Maintenance of Mother / Infant immunization card.</li> <li>– Motivating other families.</li> </ul> <p>Motivation of target group.</p> <p>Help enumeration of immunization services at fixed intervals.</p> <p>Maintain records.</p> <p>Referral of cases with adverse reactions.</p> <p>Tracking drop outs and non-participants.</p> <p>Help surveillance of neonatal deaths and outbreak of Measles, Poliomyelitis.</p>
<b>Sub Centre Level</b> Health Worker – Female (HW-F)	<p>Provide immunization services once every month.</p> <p>Maintain cold chain</p> <p>Maintain records.</p> <p>Track drop outs and monitor coverage.</p> <p>Education of mothers.</p> <p>Referral.</p>
<b>PHC/Urban Centre</b> Medical officer/ Nurses	<p>Provide immunization services once every week.</p> <p>Maintain cold chain</p> <p>Maintain records.</p> <p>Monitor programme coverage.</p> <p>Storage and distribution of vaccine.</p> <p>Training of staff imparted by MOs PHC.</p> <p>Surveillance.</p> <p>Education of mothers.</p>
CHC/Dist. Hospital First level referral facility	<p>Provide immunization services daily or more than once a week.</p> <p>Maintain records.</p> <p>Monitor programmes.</p> <p>Storage and distribution of vaccine.</p>
Specialist SMO/DHO/DIO Supt. Hospital	<p>Surveillance.</p> <p>Investigate and manage adverse reactions.</p> <p>Education of mothers.</p> <p>Training of staff.</p>



## MESSAGES TO MOTHERS

- ◆ Protect your children with all the immunizations under National Immunization Program.
- ◆ There are very few reactions with vaccines and they are always far less serious than the complications of the diseases that they prevent.
- ◆ Take children below 5 years to your local health center for the pulse polio immunization in December and January.
- ◆ Pulse polio immunization is in addition to the routine immunization program, not a substitute for it.

### 1.12 ADVERSE REACTIONS AND MANAGEMENT

#### **1.12.1**      *Reaction after immunization are very very mild and of short duration such as:*

- ◆ Mild fever.
- ◆ Mild rash after Measles immunization.
- ◆ Pain, redness and swelling at the site of injection.

#### **Management :**

Give Paracetamol tablets as and when required :

Dose :      ¼th Paracetamol tablet (500mg)

#### **When to refer:**

- ◆ Baby is crying for more than 3 hrs. after immunization.
- ◆ High grade fever ( more than 38°C or 100.4°F)
- ◆ Baby is drowsy, convulsing or unconscious.

**Immediately refer to the nearest doctor.**



### 1.13. SOCIAL MOBILIZATION

#### Know and work with your community

A community is a social group determined by geographical boundaries and / or common values and interests.

As a health assistant in a rural community, you are part of the community. You must, therefore, work very closely with the community, and other community level workers, e.g. the village health guides, anganwadi workers, balsevikas, gramsevikas and dais working within the same community.

If your service to the community are to achieve their objective, you must create a demand for these services within the community. This demand can be created by:

- Involving the community in all aspects of health services delivery, i.e. in the planning delivery, utilization and evaluation of child survival and safe motherhood activities.
- Inter-relating the services with other social systems operating within the community. e.g. Panchayat / MLA / MP of area
- Shaping the services around the life patterns of the community.
- Relying on the community to provide and mobilize its own resource to assist in the provision of the health care.
- Educate the people in the community about the importance of immunization.

Involving the Community Leaders in RCH programme your success will depend on how far you get the support of the community leaders. Identifying these influences which are given under the section "Communication, Demand Generation, and Social Mobilization". You should ensure that your relationship with them remains cordial, friendly, cooperative and promotes team work. Participatory approach in health work calls for you to:

- Enquire what are the current health needs of the community. List them according to priority.

- Relate these needs to the objectives of RCH programme. Ensure that your activities will satisfy some of their needs. If you are unable to satisfy their needs, explain to the leaders why you cannot do so. Discuss what they could do to meet their requirements with your cooperation.
- Plan with the community leaders, the timing and other aspects of the health programmes.
- Request the help of the leaders in the delivery of the health services.
- Enquire from the leaders whether the community is satisfied with the services or not. If not, ask why and try to find ways, in consultation with the leaders, for improving the programme.
- Stimulate the leaders to relate health programmes with other developmental programmes for the community.
- Get the leaders to motivate members of the community who are resistant to health programme.
- Remember that if a programme is planned and operated with community participation, they will own up the programme and cooperate fully. Their interest will be maintained. The programme will be more effective and lasting.
- Plan for meetings with the leaders from time to time either individually or in groups.

## QUESTIONS

Q1. Name vaccine preventable diseases?

- (a)
- (b)
- (c)
- (d)
- (e)
- (f)

Q2. In which route the following vaccines are given?

- (a) B.CG      (b) Polio   (c) DPT   (d) Measles

Q3. How will you take vaccines for PHC to your sub-centre?

Q4. How Polio can be eradicated?

Q5. How neonatal tetanus can be eliminated?





## **UNIT – 2**

### ***NUTRITION***

#### **LEARNING OBJECTIVES**

*At the end of this unit the participants should be able to*

- Provide support to the mother for initiating and sustaining breastfeeding.
- Advise mother regarding introduction of indigenous home made complementary foods at appropriate time.
- Assess nutritional status & growth of the child and detecting major nutritional deficiency states.

#### **CONTENTS**

- 2.1 Introduction.
- 2.2 Importance of nutrition in child's health and advantages of Breastfeeding.
- 2.3 Role of Health Assistant.
- 2.4 Complementary feeding and appropriate weaning practices.
- 2.5 Major nutritional deficiencies.

#### **2.1 INTRODUCTION**

Why Nutrition is an important issue?

Good nutrition forms the basis for good health of a child. Well-nourished children, particularly girls, will grow up to be tall and healthy adults and be able to bear healthy babies. However, malnutrition is still widely prevalent in our country. More than half of the children in our country is moderate to severely malnourished.

Malnutrition reduces body resistance to fight infections, reduces intellectual and physical development. This also leads to increased morbidity and mortality in children.

## **2.2 IMPORTANCE OF NUTRITION IN CHILD'S HEALTH AND ADVANTAGES OF BREASTFEEDING.**

Nutrition is required for a child to grow, develop, keep active and to reach the adulthood as well. Several of these nutrients are essential and their deficiencies leads to various problems. These essential nutrients are carbohydrates, proteins, fats, vitamins and trace elements which are responsible to maintain growth, develop and tissue integrity.

### **Breastfeeding**

Breast milk is the ideal food for the newborn child. Exclusive breast-feeding can save many lives by preventing malnutrition and reducing risk of infections during early infancy. **Exclusive breastfeeding means that except for breast milk no other food or fluid, including water & prelacteal feeds should be given to a child from birth to 6 months. Breast feeding should be started as soon as possible after birth preferably within half an hour of birth.**

Feeding anything other than breast milk, including water not only unnecessary but is potentially harmful during first 6 months.

#### **2.2.1 *Advantages of breast –feeding***

##### **(i) Ideal food**

Breast milk contains all the nutrients needed for the first 6 months of life and it is specific for human babies.

##### **(ii) Prevents malnutrition**

Mother produces enough milk for adequate nutrition of her baby. In exclusively breastfed babies, chances of under nutrition are rare.

### **(iii) Protection against infections**

Breast milk is clean & free from bacteria. It contains anti-infective factors that help to fight infection. The initial breast milk called colostrum is particularly rich in anti-infective factors.

Exclusive breastfed babies:- have a significantly **lower risk to develop diarrhea and pneumonia. It protects against allergies, eczema and asthma. Breastfed babies have lesser chances of developing allergic disorders during childhood and adult life.**

### **(iv) Bonding**

Breastfeeding creates a strong bond between a mother and the baby and helps in the emotional, intellectual and social development of the child.

### **(v) Benefits to mother**

Exclusive breastfeeding has contraceptive effect in the first 6 months after delivery. Other benefits to the mother include early involution of uterus, decreases the risks of post partum hemorrhage and protective effect against breast and ovarian cancer.

**No prelacteal feeding; which is dangerous.**

**Feeding colostrum is the 1<sup>st</sup> immunization and food for the baby.**

**Exclusive breast fed baby does not need extra water even in summer days**

**Initiation of breastfeeding:**



## **2.3 YOUR ROLE :**

### **2.3.1 Role of Health Assistant**

Encourage frequent feeding on demand.

Assure anxious mother

Strongly **discourage** bottle feeding

Majority of mothers in our country give breastfeed however, due to misconceptions about quantity & quality of their milk, they tend to introduce top milk.

## **2.4 COMPLEMENTARY FEEDING AND APPROPRIATE WEANING PRACTICES**

### **Give feeding advice according to age**

Ask the mother to describe how the child is being fed. This can be done by asking the questions that are listed on the chart. (Section 2.4.2)

Determine the feeding problems that you have identified on the basis of mother's description and matching it with feeding recommendations.

Give only the feeding advice that is needed for the child's age and situation. (To avoid confusion, advise not more than 2 changes in feeding).

Get mother's agreement to make the changes in the child's diet that you have suggested.

### **Assess the child's feeding**

**The assessment of the child's feeding is necessary if the child is very low weight for age or if the child is less than 2 years age.**

### **Ask the following questions:**

Do you breast feed the child?

How many times in the day?  
 Do you breast feed the child during the night also?  
 Does the child take any other foods or fluids?  
 What foods or fluids?  
 How many times per day?  
 Are the foods thick or thin?  
 What do you use to feed him?  
 In the case of under nutrition  
 How large are the servings (katori, tea-spoon)?  
 Does the child receive his own separate serving?  
 Who feeds the child and how?  
 Ask if the child's feeding has changed during this illness? If yes how?

### **2.4.1      *Identify feeding problems***

The differences between what is recommended for age and what the child is fed are the feeding problems.

You should identify all the feeding problems before advising on feeding.

**Common feeding problems that are observed include the following:**

- **Difficulty in breast feeding**
- **Giving sugar water or tea before six months of age**
- Breast milk is not considered to be enough
- Feeding bottle is used for giving milk
- Lack of active feeding (child fed by the mother or another caretaker, is fed from his own serving which is not shared with others)
- The child does not feed well during the illness.

The common feeding problems and their possible solutions are listed in the table.

**2.4.2 Selected feeding problems and “what you should do?” to correct them:**

Feeding problems	Possible solution
Mother reports that her 2 month-old baby is having difficulty in breast feeding well.	<ul style="list-style-type: none"> <li>• Assess breast feeding, watch the mother and breast feed the baby.</li> <li>• Show the mother correct positioning and attachment.</li> <li>• Refer if there is a sore nipple or if breast is infected.</li> </ul>
A 3 month-old baby is given sugar and water and liquid food in addition to breastmilk.	<ul style="list-style-type: none"> <li>• Explain that breastmilk is a complete food for the baby until at least 6 months age.</li> <li>• Breast feed more often and for longer duration both during the day and at night.</li> <li>• Sugar water and liquid foods should be discontinued.</li> </ul>
Breastmilk is not enough and animal milk has to be given to a 2 month-old child.	<ul style="list-style-type: none"> <li>• Animal milk should not be diluted with water.</li> <li>• Finish animal milk within 1 hour.</li> <li>• Do not give animal milk by a bottle with nipple, the child should take it from a clean cup.</li> <li>• Try and encourage mother to breast feed more often and for longer periods both during day and at night.</li> </ul>
A 2 month-old baby has to be fed by bottle since the mother has died.	<ul style="list-style-type: none"> <li>• Recommend substituting a cup for a bottle.</li> <li>– Show the care taker how to feed the child with a cup.</li> <li>– Hold the baby upright or semi upright on your lap.</li> <li>– Hold the cup on the baby’s lips and tilt it so that milk reaches the lips.</li> <li>– The child will open its mouth and suck it or lick it.</li> <li>– Let the child take the milk by himself. Do not pour it into his mouth.</li> <li>– The baby will stop taking milk when it is satisfied.</li> </ul>
The 2 year-old child is not	<ul style="list-style-type: none"> <li>• Sit with the mother, child and other</li> </ul>



actively fed	<p>family members to encourage feeding.</p> <ul style="list-style-type: none"> <li>• Tell the mother to give the child adequate serving on a separate plate or bowl.</li> <li>• Give small and frequent feeding</li> <li>• Adequate serving means that some food is left when the child has finished eating.</li> </ul>
The 9 month-old child is not feeding well during illness	<ul style="list-style-type: none"> <li>• Breast feed more frequently and for longer periods both during the day and at night.</li> <li>• Use soft, varied foods, try giving the child's favorite foods to encourage him to eat as much as possible.</li> <li>• Offer small feedings frequently.</li> <li>• Reassure the mother that the child's appetite will improve as the child feels better.</li> </ul>

There may be other feeding problems that you may identify and on. Consult your supervisor for finding solutions.

Before talking to the mother you should review the feeding recommendations according to the age of the child. The feeding recommendations for each age group are summarized below:

### 2.4.3 Feeding Recommendation

**Age: Up to Six months**



**Fig. 8**  
**Breast feeding**

Give exclusive breast-feeding (Fig. 8). This means that the child should not be given anything else by mouth not even water. Remember that no extra water is required for an exclusively breast-fed baby even if the weather outside is very hot. There is always enough water in breast milk to protect the baby from getting dehydrated.

Breast-feed the baby as often as the baby wants at least eight times during the day and night. The baby should be breast-fed at night.

Do not give water, food or other fluids for any reason unless advised specially by a doctor.

**Do not give pacifier to the baby.**

#### **2.4.4                      Complementary feeding** (Feeding semisolid foods)

Continue to breast feed the baby **at least eight times in the day and night**. For some children foods other than breast milk may be required additionally in this age group. The first foods given to the baby in addition to breast milk are called **complementary foods**.

The mother should start complementary foods if her child shows interest that is reaching out for food, or opens the mouth when offered food. Complementary foods should also be started if the baby is not gaining weight or appears hungry after breast-feeds. The child should continue to be breast-fed also during this age. Breast-feed as often as the child wants.

- **If the child is breast-fed then give complementary foods at least three times in the day. If not breast fed the complimentary foods should be given five times in the day.**
- **A child who is not breast-fed may be given animal milk undiluted by a cup.**

**Never use a feeding bottle.**

#### 2.4.5

*Age: 6 months up to 12 months*



Fig. 9

The child should continue to be breast fed during this age. Breast feed as often as the child wants.

If the child is breast fed then give complementary foods at least 3 times in the day. If not breast fed the complementary foods should be given 5 times in the day.

A child who is not breast fed may be given animal milk undiluted by a cup. Never use a feeding bottle.

The child should be actively fed. The mother should be present when the child is getting the complementary foods (Fig. 9). The portion for the child should be separate from that of other family members. After the child has finished eating, some food should be left over in the plate/bowl.



#### **2.4.6**      *Age: 12 months up to 2 years*

Breast-feeding may be continued if the mother and baby like it.



**Fig. 10**  
**Feeding the baby from family food**

The variety in the diet should be increased by including the family foods (Fig. 10) in the diet of the child. Family foods should be chopped so that they are easy for the child to take. They must not be spicy.

If possible at least once in the day the child should be given a food that is made especially for the child.

The child should be offered food at least 5 times in the day.

#### **2.4.7**      *Age: 2 years and older*

The family foods should be given to the child three times in the day.

#### **Give family food**



**Fig. 11**  
**Child is taking from family food.**

The family foods should be given to the child 3 times in the day.

Two extra feedings should be given to the child. These can be family foods or other foods that are especially cooked for the child (Fig. 11).

For details about the feeding recommendations consult the chart. (Table 1). After discussion with the supervisor the decision should be made about what is considered as nutritious and the selection should be based on the easy availability, local acceptance and affordable cost of the food. You can then discuss with the mother about giving these as complementary foods.

## 2.5 UNDERNUTRITION

Advising mothers

### 2.5.1 *Feeding advice*

Children are at greatest risk of becoming undernourished below the age of 2 years. Many children are born low birth weight and their needs for food are high because they are constantly growing and are very active. During this age the child often suffers from illnesses which further increase the chance of undernutrition. To prevent undernutrition, **you with the help of AWWs should review the feeding of every child below the age of 2 years and of all undernourished children above 2 years age.**

Before advising the mother, assess the child's feeding. You should review the feeding recommendations for age of the child, given below. Next, list all the feeding problems and think of possible solutions and offers possible two recommendations. Given in the table below: Do not load the mother with too many suggestions since she may be confused and not be able to follow the advice.

**During the illness or for any other reason, food should not be diluted or made thin.**



**Table 1**

Feeding Problems	Solutions
<i>Age group: Up to 6 months</i>	
1. Mother is not breast feeding exclusively.	<ul style="list-style-type: none"> <li>Breast feed at least 8 times during day and night.</li> <li>Do not give glucose water, tea, animal milk, porridge and even water. This will reduce the protection provided by breast milk.</li> </ul>
2. Mother feels she does not have enough breast milk,	<p>To increase her breast milk supply</p> <ul style="list-style-type: none"> <li>She should breast feed the baby more often and for longer period at each feed.</li> <li>Mother should eat more and drink more liquids.</li> </ul>
3. Mother goes out to work and is not able to feed the baby.	<ul style="list-style-type: none"> <li>Mother should breast feed the baby often before going to work; after returning from work; and, at night.</li> <li>If possible, she should take the baby to work and she must take brief breaks from work to feed the baby.</li> </ul>
4. Mother has flat or inverted nipples and cannot feed the baby.	<ul style="list-style-type: none"> <li>Teach the mother to gently pull the nipples and massage them with oil (do not use mustard oil). This should be done 3-4 times per day.</li> <li>Refer the child and mother to a doctor if the problem does not improve in 2-3 days.</li> </ul>
5. Mother has very sore nipples or swelling on the breast.	<ul style="list-style-type: none"> <li>Refer to a doctor.</li> <li>Breast milk should be expressed regularly every 2 hours.</li> <li>If the breast is infected, throw away the expressed breast milk.</li> </ul>
6. Child is fed by a bottle.	<ul style="list-style-type: none"> <li>Advise the mother to stop bottle feeding. This can be very harmful.</li> <li>Put the baby to breast every time baby is hungry and feed for as long as the baby suckles.</li> <li>since breast milk may take 3-4 days to improve, feed the animal milk by a cup.</li> </ul>
7. Baby is not able to breast feed.	<ul style="list-style-type: none"> <li>There may be problem in sucking, position or attachment. Refer to a doctor who can solve the problem.</li> </ul>



Feeding Problems	Solutions
<b>Age group : 6 months up to 12 months</b>	
1(a) Complementary food given is very thin.	<ul style="list-style-type: none"> <li>• Prepare suji, rice, dalia with undiluted animal milk (add butter/ghee).</li> <li>• Give mashed banana or potato with butter or ghee.</li> <li>• Ghee thick dal with added oil.</li> </ul>
1(b) Child is given very small amount of complementary food.	<ul style="list-style-type: none"> <li>• Increase the cooked food amount by 1 tea spoon at each meal until the baby longer.</li> <li>• Animal milk must never be diluted.</li> <li>• If mother is very worried that animal milk is too strong, advise her to give plain clean water after a feed.</li> </ul>
1(c) Mother has discontinued breast feeding. She considers child is too old to breast feed.	<ul style="list-style-type: none"> <li>• Breast feeding can be done up to 2 years age.</li> <li>• Ask mother to resume breast feeding by putting the baby to breast every 2-3 hours.</li> <li>• Breast milk will come back after 3-4 days.</li> </ul>
2. Complementary foods not started.	<ul style="list-style-type: none"> <li>• Tell the mother that only breast milk is not sufficient for the child.</li> <li>• Introduce soft mashed but thick food like: <ul style="list-style-type: none"> <li>➤ Cooked in oil/ghee;</li> <li>➤ Mashed potato with butter; and</li> <li>➤ Mashed cooked vegetables (peas, carrots) with oil.</li> </ul> </li> <li>• Mashed seasonal fruit (banana, chiku, mango, guava, papaya).</li> <li>• Khichari with oil or cooked dal and rice with oil.</li> </ul>
3. Complementary food is very small in amount.	<ul style="list-style-type: none"> <li>• Increase complementary food by 1 tea spoon per feed until the child takes ½ -1 cup or katori.</li> <li>• If the child cannot take large amount of food, feed 3-5 times/day instead of 3 times per day.</li> </ul>
4. Child takes breast milk and animal milk only.	<ul style="list-style-type: none"> <li>• Continue breast feeding but stop animal milk.</li> <li>• Replace animal milk feeding by complementary foods.</li> <li>• For what foods to advise, consult problem No.2</li> </ul>
5. Child does not want to eat complementary foods.	<ul style="list-style-type: none"> <li>• Offer the child its most favourite food.</li> <li>• Play with the child or distract him while feeding.</li> <li>• If ill, child may be fussy, mother will have to be more patient and persistent while feeding the child.</li> </ul>
6. Child spits out the food given.	<ul style="list-style-type: none"> <li>• Do not place the food on tip of the tongue.</li> <li>• All children will spit out the food if placed on tip of the tongue.</li> <li>• Place the food inside the mouth.</li> </ul>

Feeding Problems	Solutions
<b>Age group: 12 months up to 2 years</b>	
1. Child does not take family foods.	<ul style="list-style-type: none"> <li>• Mother or somebody in the family, who is responsible, should feed the child.</li> <li>• The food for the child should be separate from rest of the family.</li> <li>• Some food should be left behind when the child has finished the meal.</li> </ul>
2. Child does not take family foods.	<ul style="list-style-type: none"> <li>• Make sure that family foods like dal, vegetable, meat, eggs, rice are soft and mashed.</li> <li>• Do not add any chilies or spice in the child's serving.</li> <li>• Offer what the child likes.</li> <li>• Give snacks (biscuit, besan laddoo, chilku, fried potato).</li> </ul>
<b>Age group: 2 years up to 5 years</b>	
1. Child is not hungry.	<ul style="list-style-type: none"> <li>• Determine the most favourite food and offer it.</li> <li>• Give snacks the child likes (biscuits, chana, ground nut, besan laddoo, chiku, fried potato).</li> <li>• Increase the frequency of food to more than 5 times daily if the child cannot eat enough at one meal.</li> </ul>
2. Child is not actively fed.	<ul style="list-style-type: none"> <li>• Refer to the age group 12 months up to 2 years</li> </ul>
3. Family is poor and cannot give snacks between meals.	<ul style="list-style-type: none"> <li>• Get snacks from Anganwadi centre and give to the child.</li> <li>• Increase the frequency of family foods to 5 times per day instead of 3 times.</li> </ul>
4. Child is under nourished.	<ul style="list-style-type: none"> <li>• Increase the food amount by 2 tea spoons at every meal.</li> <li>• Give foods which are thick and have oil added.</li> <li>• Give food more often.</li> <li>• Include snacks (procured from Anganwadi Centre, or biscuits, chikki, chana, ground nut, laddoo, panjiri, fried potato, seasonal fruit) in between 3 meals.</li> </ul>

### **2.5.2 Advice on fluids**

During illness the child may loose excessive fluids because of diarrhoea, vomiting, fever or fast breathing. Child will feel better if offered extra fluids to drink.



Home available fluids are recommended. These will help to prevent dehydration like lassi, shikanji, kanji, coconut water etc.

Do not dilute the fluids. If mother feels that the fluid is strong for the child, you should advise some plain clean water to drink after giving the fluid.

Fluids should be given in larger than usual amounts. It is advised that fluids are given in the form of sips at every one to two minutes interval.

The best way to determine the amount of fluid is to be guided by the thirst of the child.

**Breast fed babies should be continued on breast milk. Ask the mother to feed for a longer duration and more often.**

### **2.5.3      *Vitamin A Deficiency***

#### **2.5.3.1      Preamble**

Vitamin A deficiency can lead to blindness. It is most common between 6 months to 3 years. Improving dietary practices can prevent it. A child who is not able to see during night is the early symptoms of Vit A deficiency

#### **Prevention**

- ▣ Promote exclusive breastfeeding and feeding of colostrum.
- ▣ Provide Vitamin A mega doses to children between nine months to three years of age at six monthly interval.
- ▣ Promote intake of balanced food, including green leafy vegetables and yellow fruits.
- ▣ Increase coverage with measles vaccine.



Blindness due to vitamin A deficiency can be prevented by Schedule of mega doses of vitamin A

Dose No.	Age	Dose
1	9 months	100,000 I.U.
2	15 months	200,000 I.U.
3	18-24 months	200,000 I.U.
4	24-30 months	200,000 I.U.
5	30- 36 months	200,000 I.U.

Vitamin A solution is available in PHC in the form of a liquid preparation. Each ml. of this contains 100,000 I.U. of Vitamin A.

#### **2.5.3.2 Iron deficiency anemia**

Anemia due to deficiency of iron is very common in children and results from:

- ▣ Inadequate intake in the diet.
- ▣ Increased losses as take place with recurrent diarrhoea and worm infestations.

#### Diagnosis

- ▣ It can be recognized by noting paleness of the hands, lips, tongue and the conjunctiva.

#### Treatment

- ▣ Advise the family to have food rich in iron such as fresh, green leafy vegetables, pulses, Jagri and Raggi porridge.
- ▣ Advise mother about good hygiene in order to prevent diarrhea and worm infestations.

- ▣ In iron deficiency anemia, administer IFA small tablet. Once daily for 100 days.
- ▣ Such cases should be referred to the medical officer for confirmation of diagnosis and appropriate management.

### **2.5.3.3 Protein calorie malnutrition**

Malnutrition is a very important problem in India. It can be caused by recurrent illnesses such as diarrhea. It requires prompt detection and treatment.

Features of malnutrition

#### **Causes :**

- No breastfeeding/partial breast feeding and/or use of diluted milk.
- Delayed introduction of complementary feeding and use of diluted milk.
- Late introduction of semi solid food
- Ignorance and Poverty.
- Infections e.g. Measles, Diarrhoea.
- Psychological trauma ( separation from mother, birth of new siblings )



**Fig. 12**

#### **Clinical Features :**

- Weight not as per the age (less weight for age).

- Wasting of subcutaneous tissue and muscles
- Swelling of the baby.

### **Management:**

- Those who are able to take food, advice the mother to give more food from common family diet and also you discuss with AWWs of your area for nutritional rehabilitation.
- Those children who are not taking food / vomiting on feeding / diarrhoea. Refer them to PHC/FRU.

### **QUESTION**

- Q.1 Which of the following should be given to the newborn?
- |                    |                 |
|--------------------|-----------------|
| (a) Ghutti         | (b) Honey       |
| (c) Breast feeding | (d) Plain water |
| (e) Glucose water  |                 |
- Q2. What you mean by exclusive breast feeding?
- Q3. What is complementary feeding?
- Q4. What are feeding problems you have come across?
- Q5. What are the causes and signs of malnutrition?
- Q6. Why child gets night blindness, how can it be prevented?



## **UNIT – 3**

# ***ACUTE RESPIRATORY INFECTIONS***

### **LEARNING OBJECTIVES**

*At the end of this unit you should be able to:*

- Assess child with cough and identify no pneumonia, pneumonia, severe pneumonia and very severe illness.
- Identify how to count breathing rate and to look for chest in-drawing.
- Treat children with no pneumonia and pneumonia
- Identify children of severe pneumonia and very severe illness and advice referrals correctly
- Educate the mother on home management

### **CONTENTS**

- 3.1 Introduction
- 3.2 Assessment of child with cough.
- 3.3 How to classify cases of cough.
- 3.4 Treatment of ARI.
- 3.5 Prevention of pneumonia.
- 3.6 Referring the child with severe pneumonia / very severe illness.

### 3.1 INTRODUCTION

Acute respiratory infection (ARI) is an important cause of death in our country. In acute respiratory infections, deaths due to pneumonia are most frequent.

Hospital records from states with high IMR shows that up to 13% of inpatients deaths in paediatric ward are due to ARI. Most children have about 4 to 6 episodes of acute respiratory infections each year. Fortunately, most children with these infections recover and can be treated well at home by their families without antibiotics.

It is a fact, one of the two most common causes (with diarrhea) of death in children. Without effective treatment, the child may die within 3 days of onset of illness – Many lives can be saved if therapy with an effective antibiotic is started early.

Cough, difficult breathing, fever and running nose are some of the common symptoms, which a child with respiratory infection presents. You must be able to identify the few sick children having pneumonia amongst these cases.

Deaths due to pneumonia occur because of **three** reasons

- **Children come for treatment, but receive poor treatment**
- **Children come for treatment, but come too late**
- **Children do not come for treatment.**

### 3.2 ASSESSMENT OF A CHILD HAVING COUGH OR DIFFICULT BREATHING

“Assess” means obtaining information about the child’s illness by asking the mother questions, looking at and listening to the child.

### **3.2.1 Ask the mother**

**3.2.1.1.** Age of the child? *Pneumonia in a child less than two months of age is serious illness and must be referred immediately.*

**3.2.1.2.** Is the child coughing? For how long? – Children with cough more than 30 days must be referred.

**3.2.1.3.** Has the child had fever? For how long? – Children with fever for more than 5 days must be referred.

**3.2.1.4.** Inability to drink – It means serious illness and the child should be referred.

**3.2.1.5** Has the child had convulsion.

Ask the mother if the child has had convulsions during the current illness.

#### **(i) Age 2 months to 5 years.**

- Is the child able to drink?
- The child is not able to drink at all. This includes the child who is too weak to drink when offered fluids, is not able to suck or swallow or who repeatedly vomits and retains nothing.

#### **(ii) Age less than 2 months:**

Has the young infant stopped feeding well?

This question is similar to the one listed above. In the young infant, the sign is inability to breast-feeding. Mothers can estimate changes in the amount of breast feeding from the length of time the child sucks.



### 3.2.2

#### (1) Look for Fast Breathing (Fig. 13)



**Fig. 13**  
**Counting fast breathing**

- Expose the chest completely before counting of the respiratory rate.
- Count breathing rate for one full minute.
- Count the breathing rate only when the child is calm and quiet.  
**The breathing rate may be falsely increased if the child is crying.**
- Count respiration rate by looking at the abdomen or lower chest movement.

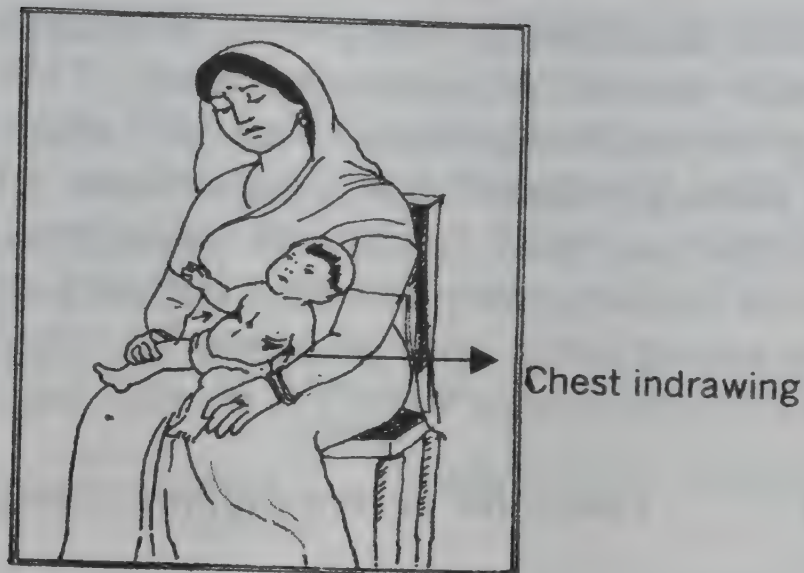
To count the breathing rate use a watch with a second's hand. Place the watch where you can see the second hand clearly. After counting the breathing rate for one minute decide whether the child has normal breathing or fast breathing.

If the child is Below 2 months	Has fast breathing if you count 60 breaths per minute or more
2 – 12 months	50 breaths or more per minute
12 – 60 months. (1-5 yrs)	40 breaths or more per minute

If count comes exactly 60, 50 and 40 breathing per minute as per the age mentioned above then consider counting second time for deciding fast breathing.

### 3.2.3

#### (2) *Look for Chest Indrawing (Fig. 14)*



**Fig. 14**  
***Chest indrawing***

- Look for chest indrawing at the lower chest wall.
- Make sure that the child's lower chest is fully exposed and you can see it clearly while checking for chest indrawing.
- Normally the lower chest wall comes out when the child breathes in.
- Chest indrawing is present when the whole of the lower chest wall goes in as the child breathes in (inspiration).
- Chest indrawing must be present all the time as you are checking for it.
- Chest indrawing is not present if seen when the child is feeding, or crying or upset or if the chest indrawing is present in one position and not in another.
- If the child's nose is blocked, you must clear it before deciding about chest indrawing.

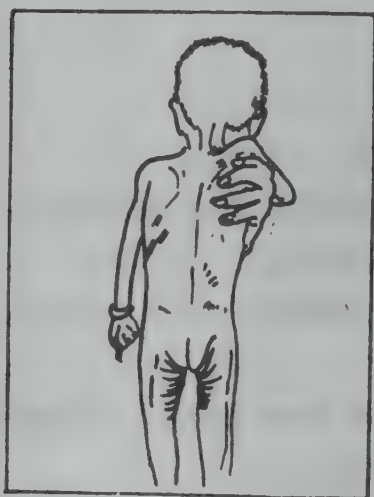
Chest indrawing in a child with cough or difficult breathing indicates **danger**. Such children should be **referred to a hospital** since the child may need special treatment like oxygen and antibiotics by injection.



### **3.2.4 See if the child is abnormally sleepy or difficult to wake**

An abnormally sleepy child is drowsy most of the time when the child should be awake and alert. This sick child often will not look at the mother or watch your face when you talk. The child may stare blankly. See if the child awakens when the mother talks or when you clap your hands. A child who is difficult to wake may continue to sleep even with the mother's voice or a loud clap. Even a very young baby, who sleeps a lot, should awaken naturally with these disturbances or when the mother begins to undress the child.

### **3.2.5 Check for severe malnutrition (Fig. 15)**



A child is considered as suffering from severe malnutrition when there is wasting of subcutaneous fat and muscles so that the child looks like skin and bones (Fig. 15) or when child has generalized swelling of the body which can be easily demonstrated at the feet. ARI or any illness associated with malnutrition is very dangerous and should be treated as very severe illness.

**Fig. 15**  
**Severe malnutrition**

### **DIAGNOSIS OF PNEUMONIA :**

#### **0-2 Months (Infants).**

Infants aged 0-2 months, with a respiratory rate of 60 per minute or more will be referred immediately to the PHC or dispensary.

**Age 2 months to 5 years:**

### **3.2.6 Abnormal sound during breathing**

Many children with ARI may have noisy breathing. Clean the nostrils. If the sound still persists it is a sign of very severe illness.



### 3.3 HOW TO CLASSIFY COUGH?

Cases of acute respiratory infections generally present with symptom of cough, of the acute respiratory infections pneumonia is the common cause of death. So for the operational purposes these cases are classified as; **No Pneumonia, Pneumonia and Severe Pneumonia / Very Severe illness.** The table I below summarizes the conditions, action to be taken and where they can be treated.

**Table – I**





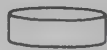





CONDITION	ACTION TO BE TAKEN	WHERE TO TREAT
NO PNEUMONIA  No fast breathing	Home made remedy	Can be treated at home
PNEUMONIA  Fast breathing. Respiratory rate Age (per minute) (months) • 50 or more 2 – 12 • 40 or more 12 -60	Cotrimoxazole Oral	Can be treated at home/health facility centres
SEVERE PNEUMONIA / VERY SEVERE ILLNESS  <ul style="list-style-type: none"> <li>• Age &lt;2 months breathing rate 60/min. or more.</li> <li>• 2 months – 5 years - Fast breathing and or chest indrawing</li> <li>• Inability to drink.</li> <li>• Excessive drowsiness.</li> <li>• Noisy breathing.</li> <li>• Blue colour nails and lips.</li> <li>• Convulsions</li> <li>• Severe malnutrition</li> <li>• Cold to touch.</li> </ul>	<b>Refer:-</b> Immediately after giving one dose of Cotrimoxazole or Paracetamol	<b>Patient should be admitted in the nearest hospital where oxygen facilities are available</b>

**NOTE:** Children less than two months who have fast breathing are always treated for severe pneumonia and their assessment and management is discussed separately, Refer them immediately.

### 3.4 TREAT PNEUMONIA WITH COTRIMOXAZOLE (PEDIATRIC TABLETS, EACH TABLET CONTAINS SULPHAMETHOXAZOL 100 MGM AND TRIMETHOPRIM 20 MGM)

A child with cough or difficult breathing who has no chest indrawing but has only fast breathing can be treated at home. This child should be treated with Cotrimoxazole. Give Cotrimoxazole by mouth every morning and every night for five days the dose of Cotrimoxazole according to age given in table 2.

**Table – 2**

Age	Tablet	Twice a day	
		 Doses	
<b><i>Upto 1 months</i></b>	<b><i>1/2</i></b>		
<b><i>1-2 months</i></b>	<b><i>1</i></b>		
<b><i>2-12 months</i></b>	<b><i>2</i></b>		
<b><i>1yr-5yrs</i></b>	<b><i>3</i></b>		

#### 3.4.1 Reassess and follow up:

- Condition of the child should be assessed after 48 hrs. if shows improvement continue for another three days.
- No sign of improvement or worsening (i.e. no chest indrawing, able to drink, no convulsion or cyanosis) continue for another 48 hrs and reassess the patient.
- After 48 hrs. worsens (i.e. chest indrawing, not able to drink, convulsion or cyanosis) immediately refer to PHC / FRU for assessment and treatment.

### Condition of the child after 48 hours

S.No.	Condition	Action to be taken
1.	Improvement	Continue treatment for 3 days more
2.	No sign of improvement but not worsening (i.e. no chest indrawing and able to drink, no convulsion)	Continue treatment for 3 days
3.	Worsening i.e. chest indrawing / not able to drink / convulsions	Refer immediately to the nearest hospital with oxygen facilities.

#### 3.4.2 Teach the mother how to give Cotrimoxazole to the child at home.

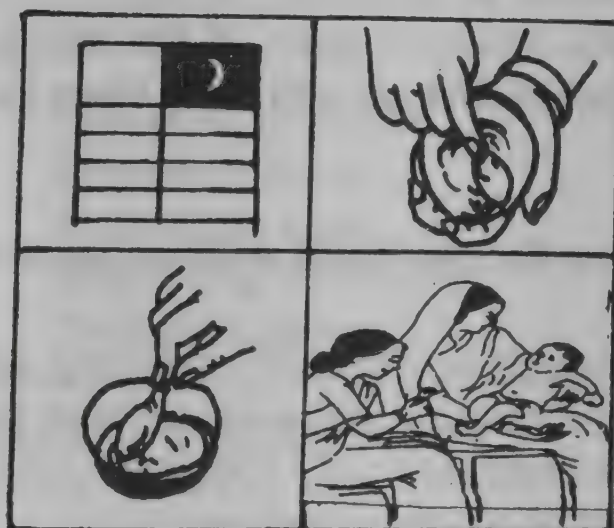


Fig. 16

- Tell the mother the reason for giving the medicine to the child
- Tell the mother how much of medicine to give, how often and for how many days.
- Cotrimoxazole is provided in the form of tablets. Show the mother how to crush the tablet into a powder.
- Next show to the mother how to mix the crushed tablet with a small amount of breast



- milk, clean drinking water, porridge, banana or some other food so that the child will eat.
- Ask the mother to give the medicine to the child in your presence.
- The medicine should be given again if the child vomits it out within half an hour
- Ask the mother checking questions to make sure that she has understood all the steps of preparing the medicine.

### **3.4.3      *Follow up of the child***

You must assess the child after 2 days. Most of the children with pneumonia get better in 2 days treatment with Cotrimoxazole. Emphasize to the mothers the need to continue the medicine and complete the full 5 days course so that the disease does not come back. If the child has not improved - check to make sure that the mother gave the medicine as advised. If the medicine was not given correctly, she should be advised again. **If the child does not improve inspite of giving the medicine as advised, then the child should be referred.**

### **3.4.4      *Home care for the child with no pneumonia***

The child with cough or difficult breathing who has no signs of very severe illness, i.e. chest indrawing or fast breathing does not have pneumonia. The child has only cough or cold. Treat with home care advice to the mother as given below:

- Keep the child warm.
- Clean the nose if blocked as it interferes with feeding. To clean the nostrils use a piece of clean cloth and soak it with home made saline solution.
- If fever give paracetamol.
- Give sufficient fluids and continue breast feeding (Fig. 17).



**Fig. 17**  
**Breast feeding**

- Increase feeding after illness.
- Give safe home made remedies for cough i.e. honey, ginger, tulsi etc. (Fig. 18)



**Fig. 18**  
**Giving home made cough remedy**

Teach the mother to look for signs of illness and **when to return to the worker. These are:**

**Signs :**

1. **Not able to drink**
2. **Become sicker**
3. **Breathing fast**
4. **Breathing difficulty**
5. **Develops fever**

### **3.5 PREVENTION OF PNEUMONIA**

#### **3.5.1 Continue breast feeding: (Fig. 19)**

You ensure exclusive breast feeding which has significantly lower risk to develop Pneumonia. It also protects against allergies and asthma.



**Fig. 19**  
**Continue Breast feeding**

### **3.5.2      *Immunization***

You ensure every child is given BCG, DPT, Polio and Measles immunization at the right age to prevent Pneumonia.

### **3.5.3      *Vit. A prophylaxis***

You ensure the timely administration of Vit. A doses to all children below 3 years of age.

### **3.5.4      *Nutrition***

You will educate the mother to maintain proper and adequate nutrition to the child as per age.

### **3.5.5.      *Avoid exposure to dusty and smokey environment***

You educate mothers during mother's meeting and or home visit to avoid baby's exposure to cold, dusts and smokes.

## **3.6              REFERRING THE CHILD**

- Explain the mother / relatives of the child the need for treatment in the hospital. If she (mother) refuses to go to hospital, identify the reasons. Help her to calrify her fear / difficulties.
- Mother should accompany the baby.
- Help to arrange transport to reach the referral centre.
- Give a dose of co-trimaxzole and paracetamol as indicated before referral.
- Ensure the mother keeps the warmth during transport.
- Give a referral note to the mother, mentioning the followings:
  1. Signs you have seen.
  2. Your classified illness.
  3. Treatment you have given.
  4. Past treatment if any.



## Exercise

- Q.1. Deaths due to Pneumonia occurs because of:
- a.
  - b.
  - c.

### Q.2. Exercise A

Jyoti is 10 months old. Her mother tells you that she has cough and difficult breathing since 3 days. Although Jyoti is not eating well she is able to drink. Jyoti has a respiratory rate of 72 per minute and temperature of 102<sup>0</sup>(F). She has no chest indrawing. There is no stridor or wheeze. Her nutritional status appears normal. Although she resents examination, she is otherwise alert.

- A) List all signs of Jyoti's illness
- B) What is Jyoti suffering from?  
Give reasons for your decision.
- C) What treatment would you prescribe for Jyoti's illness

### Exercise B

Mohan is six-month-old. His mother tells you that Mohan has cough and difficulty in breathing for the past 2 days. On examination you find his respiratory rate to be 60 per minute and chest indrawing present. Mohan's temperature is 39.6 deg c. Mohan is alert, does not have stridor or wheezing. Mohan is undernourished but able to drink.

- A) List all the signs of illness
- B) What is Mohan is suffering from?
- C) How would you treat Mohan?

- Q.3. What advise you will give to mother to prevent Pneumonia.



## **UNIT – 4**

### ***DIARRHOEA***

#### **LEARNING OBJECTIVES**

*At the end of this unit you should be able to:*

- Define what is diarrhea.
- Identify signs of dehydration in a child suffering from diarrhea.
- Treat a child with no dehydration and dehydration with home available fluids (HAF) and ORS.
- Refer all children suffering from severe dehydration, blood in stool and persistent diarrhoea.
- Educate the mother how diarrhoea can be prevented.

#### **CONTENTS**

- 4.1 Introduction
- 4.2 What is diarrhoea?
- 4.3 What is not diarrhoea?
- 4.4 What are the types of diarrhoea?
- 4.5 What are the effects of diarrhoea on the health of a child?
- 4.6 Outcome of diarrhoea
- 4.7 Assess the child with diarrhoea
- 4.8 Treatment of dehydration
- 4.9 Preparation of ORS
- 4.10 Home care during diarrhoea
- 4.11 Prevention of dehydration



## 4.1 INTRODUCTION

One of the major causes of death is diarrhoea. It is now possible to treat most of these children at home. It is also easy to identify the children who are more sick and need treatment in a hospital. Timely treatment and referral of sick cases can help in reduction of complications and death.

*This module will help you in:*

- Educating mothers to detect the signs of dehydration.
- Advising mothers about simple home care during diarrhoea
- Treating most of these cases with HAF and ORS.
- Identifying children who may be having serious illnesses and need referral.

## 4.2 WHAT IS DIARRHOEA?

### Definition of Diarrhoea:

- ♦ Change in consistency and character of stools.
- ♦ 3 or more loose or watery stools.



**Fig. 20**  
**Child having diarrhoea**

## 4.3 WHAT IS NOT DIARRHOEA?

- Transitional stool on the 3<sup>rd</sup> to 7<sup>th</sup> day of life.

- ▣ Passage of frequent formed stools or pasty stools in a breast-fed baby or immediate passage of stool after feeding should not be considered as diarrhea.

#### **4.4 TYPES OF DIARRHOEA**

**Diarrhoea is of three types:**

- i. Acute watery diarrhea: It starts suddenly and may continue for some days but not more than 14 days. Most of these are self limiting within 3-7 days.
- ii. Diarrhea with blood in stool (Dysentery)
- iii. Persistent diarrhea: Watery diarrhoea or dysentery of more than 2 weeks.

#### **4.5 WHAT ARE THE EFFECTS OF DIARRHOEA ON THE HEALTH OF A CHILD?**

- Diarrhea leads to development of dehydration in a child, in dehydration there is loss of water and various salts from the body.
- Malnutrition: it occurs due to loss of nutrients; child may not like to take food and children are not given enough food by mothers during the episode.
- It is one of the common causes of death.

#### **4.6 OUTCOME OF DIARRHOEA**

- Ninety out of one hundred diarrhoeal episodes do not develop dehydration. These can be managed at home by mothers with the use of home available fluids (HAF) and continued feeding.
- Nine out of one hundred episodes will develop some dehydration. These need to be managed at health facilities with the use of oral rehydration salts (ORS) solution.
- One out of one hundred episodes will develop severe dehydration needing intravenous infusion therapy. These need to be referred to the nearest facility where intra-venous infusion could be given.

## 4.7 ASSESS CHILD WITH DIARRHOEA

History should be taken from the patient or a family member. Ask questions to obtain information on:

- duration of diarrhoea;
- consistency of stool;
- blood in stool;
- presence of fever;
- convulsions or other problems;
- pre-illness feeding practices, type and quantity of fluids (including breast milk)
- food consumed during illness: and
- drugs or other remedies taken.

### 4.7.1 *Check the child's ability to drink*

4.7.1.1 You should offer the child with diarrhoea plain clean water to drink. If the child does not take any water at all or vomits it out completely or is not able to keep any water down, the child is not able to drink. This is a general danger sign. However, in cases of diarrhoea, not able to drink, or drinks poorly or vomits every thing is also a specific **danger sign**.

4.7.1.2 **Determine whether the child is eager to drink water.** If the child reaches out for the cup or the glass or if the child opens the mouth when the water is offered or if the child begins to cry when the water is taken away, it means that the child is drinking eagerly. This is a sign of dehydration.

**The child drinks normally** if water is taken after some encouragement by the mother.



#### 4.7.2 Check for skin pinch

Check for skin pinch in a child with diarrhoea. Ask the mother to hold the child in her lap so that the child is lying flat on its back. Locate an area half way between the child's navel and the side of tummy. Now pinch the skin with the thumb and the first finger and lift it for one second and then releasing it. Do not pinch with the tip of the finger or the thumb since this will cause pain to the child. After leaving the skin, check to see how soon the skin returns to normal.

- 4.7.2.1 If the skin comes back slowly that is it takes **more than 2 seconds the skin pinch is very slow. This indicates severe dehydration.** Very slow skin pinch is a specific danger sign in cases of diarrhoea.
- 4.7.2.2 If the skin does not return to normal immediately, the **skin pinch is slow and this means that dehydration is present.** A very short tenting of the skin is considered as slow skin pinch.
- 4.7.2.3 If the skin returns to normal after being pinched immediately, the **skin pinch is normal.**

**Assessment of the degree of dehydration  
Table – I**

1. Look : CONDITION of  EYES MOUTH & TONGUE THIRST	Well, alert  Normal Moist Drinks normally, not thirsty	Restless, irritable  Sunken Dry Thirsty, drinks eagerly	Lethargic or unconscious: Floppy Very sunken Very dry Drinks poorly or not able to drink
2. FEEL: SKIN PINCH	Goes back quickly	Goes back slowly	Goes back very slowly
3. DECIDE:	The patient has NO SIGNS OF DEHYDRATION	If the patient has two or more signs, so there is DEHYDRATION	If the patient has two or more signs, so there is SEVERE DEHYDRATION
4. TREAT	HAFS	ORS	Refer immediately

## 4.8 PRINCIPLES OF TREATMENT OF ACUTE DIARRHOEA.

**4.8.1** *All cases of severe dehydration* must be immediately referred to PHC/FRU. During referral continue breast feeding and ORS if the child is able to drink. Avail the fastest mode of transport.

**4.8.2 Fluid therapy.** In diarrhoea there is loss of water and salts (electrolytes) from the body. So fluid therapy is essential to replace the loss of water and salts (electrolytes) irrespective of the cause of diarrhoea.

**4.8.3 Feeding :** Feeding to be continued as before during diarrhoea, which should be increased during the period of recovery to avoid nutritional deficiency.

Treat Acute diarrhoea with sign of dehydration with Oral Rehydration Salt (ORS) Solution as given below.

**Table - 2**

REHYDRATION THERAPY					
Approximate amount of ORS solution to be given in the first 4 hours					
Age	<4 months	4-11 months	12-23 months	2-4 years	5-14 years
ORS (ml)	200-400	400-600	600-800	800-1200	1200-2200
Measures (glass)	1-2	2-3	3-4	4-6	6-11
If the child wants more ORS than shown, give more.					
Inform mother to give the child breast milk in between the feeds of ORS.					
For infants who are not breastfed, also give 100-200 ml. Clean water during this period.					



## 4.9 TEACH THE MOTHER HOW TO PREPARE ORS SOLUTION

One packet of **ORS** is meant to be dissolved in one litre of water.

*(Do a demonstration of preparation of ORS)*

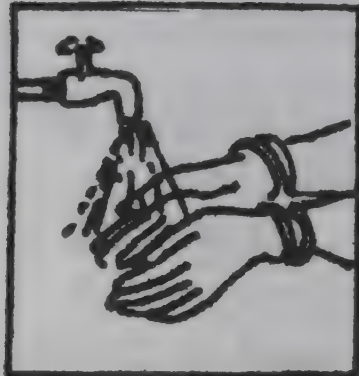


Fig. 21

Wash your hands with soap

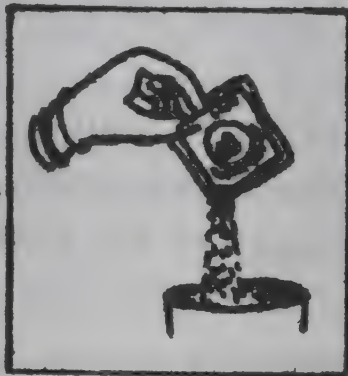


Fig. 22

Pour all the ORS powder into a container having capacity of 1 litre

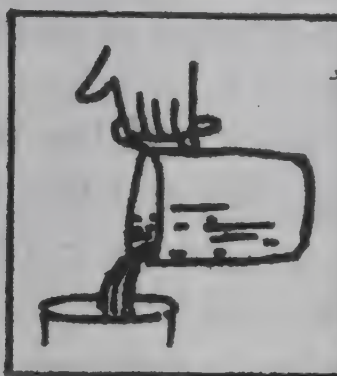


Fig. 23

Measure 1 litre of drinking water & pour it to container  
Fig. 22

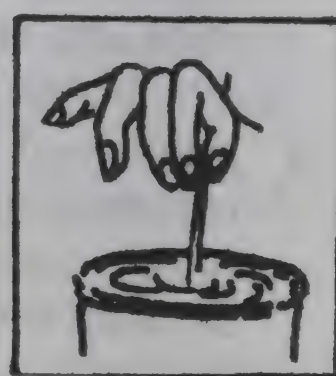


Fig. 24

Stir well until the powder is mixed thoroughly

Procedure: ( shown above fig.)

- Mother must be taught how to measure one litre of water.
- First of all identify a measure commonly available at home e.g. cup/Glass / empty CocaCola bottle and tell the mother how many measures of that will make one litre.
- Wash hands thoroughly with soap and water ( Fig 21).
- Take clean container which can hold one litre of water.
- Measure one litre of clean drinking water (not necessarily boiled and cooled) and keep it in a container (Fig. 23)
- Open the packet of ORS and pour whole content into water (Fig. 22)
- After pouring stir well with a clean long handle spoon to mix it completely (Fig. 24)
- Now the solution is ready for use. Keep the solution covered.
- It can be used for 24 hrs. if not fully consumed then discard it and prepare fresh solution for use.



#### **4.9.1      *How to give ORS solution : (show to mother)***

- Ask the mother to give one teaspoon of the solution to the child. This should be repeated every 1-2 minutes (an older child who can drink it or sips, should be given one sip every 1-2 minutes).
- If the child vomits, tell the mother to wait for 10 minutes and resume giving ORS, but this time more slowly than before
- Breast baby should be continued to be given breast milk in between ORS.
- Any ORS, which is left over after 24 hours, should be thrown away.
- After about 4 hours of giving ORS, assess the child for dehydration. If the child is better, tell the mother to give ORS or home available fluid the same way. If dehydration persists continue ORS. If the child is more sick – refer the table-I to determine the amount of ORS that should be given to the child in 4 hours

#### **4.10 HOME CARE FOR THE CHILD WITH DIARRHOEA AND NO DEHYDRATION**

**Give extra fluids:** A baby below 6 months of age should continue to be exclusively breast feed. Advise the mother to give breast feeds for longer duration and more often. Other children should be given extra amount of plain clean water, ORS, (table **3**) rice water, yogurt/curds drink or shikanji (table 4). Continue to give extra fluids until the diarrhea stops.

ORS is the best available drug for the treatment of diarrhoea in the beginning of diarrhoea when there is no sign of dehydration or when ORS is not available, home available fluid (HAF) can be used and water with usual intake of food can be advised

**4.10.1      *How much ORS is to be given? Child having diarrhoea but no clinical signs of dehydration.***

- Mother must be told to give ORS, home available fluids (tables 3 & 4) as long as diarrhoea lasts.
- Breast-feeding must be continued (appropriate for the age) In exclusive breastfed babies frequent breast-feeding is sufficient to prevent dehydration.
- Always give undiluted milk who are on milk other than breast-feeding.
- Food normally taken by the child should be continued.

**TABLE -3**

HOW MUCH ORS TO BE GIVEN FOR REPLACEMENT OF ON GOING LOSS IN STOOL TO PREVENT DEHYDRATION.	
Age < 6 months	After each liquid stool Quarter glass (50 ml).
7 months – 2 years	Quarter to half glass (50 to 100 ml)
2 to 5 years	Half to one glass (100ml-200ml)

Home available fluids (HAF)

**Table – 4**

Useful	Harmful
Lassi (Yogurt drink)	Soft drinks
Shikanji	Canned fruit juices
Rice, Kanji, Mand	Coffee
Dal water	
Plain clean water	
Coconut water	

#### 4.10.2 *Feeding during Diarrhoea*

- It is important that the mother understands the child should be fed during episodes of diarrhea.
  - Children with diarrhea usually have a poor appetite and may need to be coaxed to eat; they should, however, not be force-fed. Give Banana, Khichri.
  - Milk **should not be diluted** with water during any phase of acute diarrhea.
  - Milk can also be given as milk cereal mixtures, e.g. dalia, milk- rice mixture.
- Breast-feeding should be continued uninterrupted even during rehydration with ORS.
- After the child recovers- give more food than normal to regain lost weight.
- In case of breastfed babies, mother should be advised to increase the frequency of breastfeeding
  - Give high calorie dense food.

#### 4.10.3 **Advise to mother when to return:**

If the child has any of these signs:

- Not able to drink or breast feed
- Becomes sicker
- Develops blood in stool
- Develops fever



## 4.11 TEACH THE MOTHER FOLLOWING STEPS FOR PREVENTION OF DIARRHEA

4.11.1 Give exclusive breast-feeding for first 6 months (Fig. 25)



Fig. 25

4.11.2 Introduce semi solid foods on complete 6 months of age in a clean way.

4.11.3 Thorough hand washing before cooking and feeding the child. Also do it after defecation and washing of the containers of food (Fig. 26)



Fig. 26

4.11.4 Protect food from dirt and flies etc. (Fig. 27a)

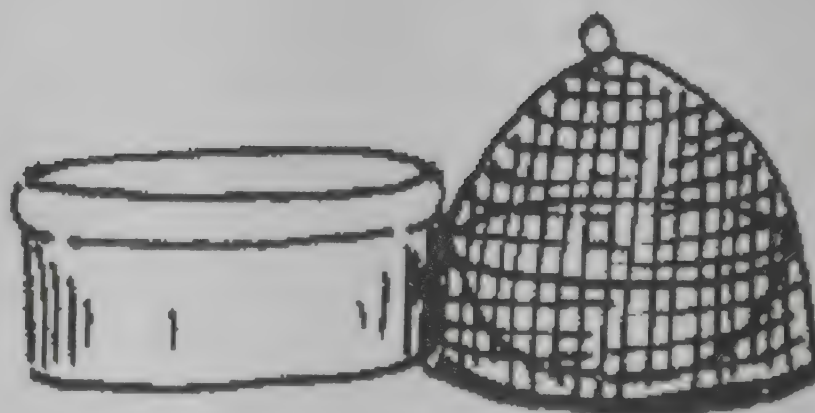


Fig. 27(b)

Fig. 27(a)

4.11.5 Give safe potable water for drinking. Keep it covered.(Fig. 27b)

4.11.6 Promote safe disposal of excreta, use latrine (Fig. 28).

4.11.7 Timely immunization especially 1 Measles.

Timely prophylaxis Vit. A to be given.



Fig. 28

### QUESTION

- Q1. What are the signs of dehydration?
- Q2. How will you treat a case of acute diarrhoea with no dehydration at home?
- Q3. How will you prepare ORS solution? Demonstrate.

## **UNIT - 5**

### ***FEVER***

#### **LEARNING OBJECTIVES**

*By the end of this unit you should be able to:*

- Understand the importance of fever as a symptom of a disease and identify cases for referral.
- Understand common signs and symptoms of malaria.
- The role of female Anopheline mosquito in the transmission of malaria.
- Collect thick and thin blood smear for examination of malaria parasite.
- Select correct dose of anti-malaria drugs.
- Recognize adverse symptoms.
- Know how to prevent malaria.

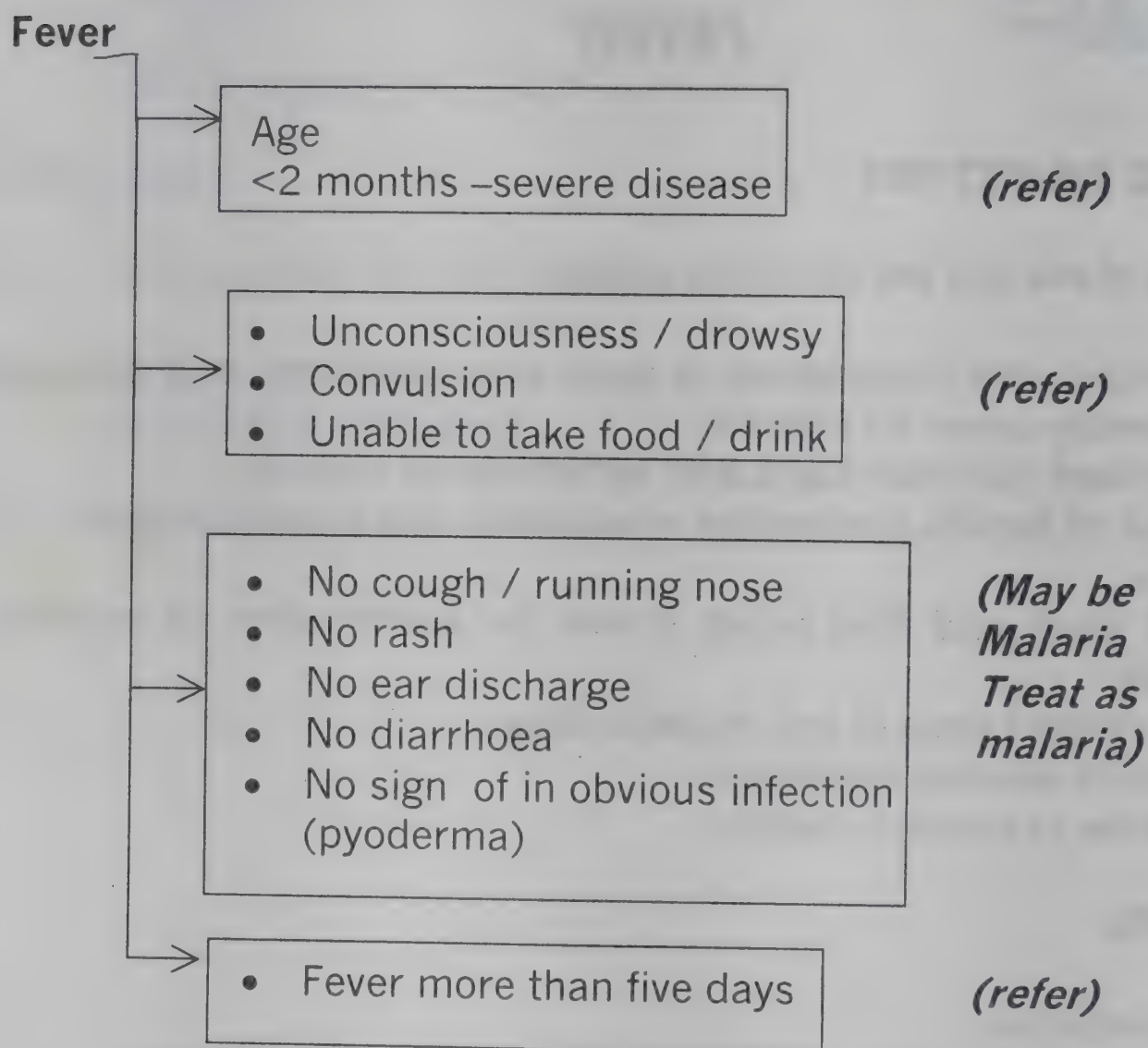
#### **CONTENTS**

- 5.1 Introduction
- 5.2 How malaria is transmitted and its symptoms and signs.
- 5.3 Management of a case of malaria.
- 5.4 Control of malaria.



## 5.1 INTRODUCTION

Acute fever is a common symptom of many diseases which may be simple or serious. A large number of cases may be viral which may subside without any treatment. In many children it may be a symptom of an acute severe illness. The boxes given below will help you to decide which case should be referred immediately.



## 5.2 HOW MALARIA IS TRANSMITTED AND ITS SIGNS AND SYMPTOMS

Malaria is transmitted by female Anopheline mosquitoes.

- ♦ Patients get chills or shivering for ½ to 2 hours followed by high fever for 8 to 12 hours.
- ♦ The fever comes on alternate days or sometimes daily.
- ♦ Patient complains of
  - Headache.
  - Body ache.
  - Vomiting.
  - Fever comes down after profuse sweating.
  - Untreated cases may have:

Enlarged spleen.

Anemia.

Weakness.

- ♦ If malaria parasite (*P.falciparum*) affects the brain, the cerebral malaria may lead to unconsciousness.

**Unconsciousness followed by death especially amongst children and pregnant women**

### **5.2.1      *In young infants***

- The classical description of symptoms given above may be absent in young infants.
- On the other hand may have low-grade fever without chill / shivering / rigor.
- All fever with chill is not malaria.
- Malaria fever may be associated with respiratory or gastro intestinal symptoms.
- So all cases of fever should be diagnosed as malaria on high degree of suspicion in children and blood smear examination should be done.

### **5.2.2      *A serious case of malaria would manifest the following signs and symptoms.***

- ♦ Hyperpyrexia i.e. Temp. 103° F or above.

- ♦ Convulsions or twitching of limbs or other body muscles.
- ♦ Change in vision – blurring or irregular movement of eye balls.
- ♦ Incoherent speech / delirium.
- ♦ Semi-consciousness or coma.
- ♦ Diarrhoea / vomiting.

***All seriously sick cases should be referred to MO PHC***

A malaria worker should always remember that:

**"MALARIA ALWAYS CAUSES FEVER AND THEREFORE ANY FEVER CAN BE SUSPECTED TO BE DUE TO MALARIA"**

Mode of transmission: By mosquito bites i.e. Anopheline mosquito.

**Malaria is not directly passed from man to man.  
Female Anopheline mosquitoes only transmit malaria. Therefore protect yourself from mosquito bites.**

Importance of blood smear collection

- ♦ The diagnosis of malaria cannot be confirmed on clinical signs and symptoms only.
- ♦ Malaria should be confirmed by microscopic examination of blood.
- ♦ For microscopic examination thick and thin blood smears are collected.
- ♦ In all cases of fever irrespective of age and sex, blood film should be taken since malaria attacks all age groups and both sexes equally.



- ♦ Old malaria infection may flare up during any other illness like after childbirth, surgery, and accidents as well as in patients suffering from other infections.
- ♦ The only method for correct diagnosis is to have blood smear.

### **5.3 MANAGEMENT OF A CASE OF MALARIA.**

#### **5.3.1 *Preparation of blood smear***

You, fever treatment depot (FTD) holder and voluntary NGOs working as FTD as well as Malarial link volunteer (MLV) will collect the blood smears at the place of their residence/work, in exceptional circumstances when the patient is confined to bed you may make a domiciliary visit for blood smear collection and administration of antimalarials.

##### **5.3.1.1 Equipment's required**

- ♦ Clean glass slides.
- ♦ Twenty pricking needles ( Hagedorn triangular – No. 12)
- ♦ Specimen tube with cork for fixing pricking needles.
- ♦ Spirit/savlon solution in a small bottle with a stopper.
- ♦ Cotton.
- ♦ Clean handkerchief.
- ♦ Lead pencil.
- ♦ Register and MF 2 forms.
- ♦ Carbon paper.
- ♦ Ballpoint pen.
- ♦ Antimalarial drugs for giving presumptive treatment.
- ♦ Soap.
- ♦ Slide box for 50 slides, the box should contain the relevant literature as well.

##### **5.3.1.2 Selection of glass slides.**

- ♦ The glass slides should be clean.
- ♦ The slides should be free from grease and dust.

- ♦ It should not have traces of old smear stains or scratches.
- ♦ The edges should be smooth.

#### **5.3.1.3 Method of preparing thick and thin blood smears**

- ♦ Clean the tip of ring finger of the patient with spirit / savlon swab and allow it to dry up.
- ♦ Hold the pricking needle in right hand and prick the cleaned finger.
- ♦ Allow blood drop to ooze out and wipe out the first drop.
- ♦ Take a clean slide.
- ♦ Take 3 drops of the blood (sufficient blood) 1.5 cm. from the edge of the glass.
- ♦ Take another drop of blood one cm from the first drop.
- ♦ Take another clean slide smooth edge and use it as a spreader. Do not use the same spreader for more than one blood smear.
- ♦ First make thin and then thick smear.
- ♦ Do it quickly before the blood coagulates.
- ♦ Allow it to dry in flat position.
- ♦ Do not keep spirit bottle inside the slide box.

#### **5.3.1.4 Precautions**

- ♦ The angle of the spreader for thin smear should be between  $30^{\circ}$  and  $45^{\circ}$
- ♦ Spread thick smear using the corner of the spreader at  $30^{\circ}$  angle.
- ♦ The spreader edges should be thoroughly cleaned after use and also before making next blood smear.
- ♦ The speed of drawing thin smear should be uniform.
- ♦ The smear should be allowed to dry flat, tilting of slide will make thick smear uneven.
- ♦ Prevent contamination with dust.
- ♦ Protect from flies because they eat away thick blood smear.

#### 5.3.1.5 Ideal thick smear

- ♦ An ideal thick smear should be 1 to 1.5 cm away from the edge.
- ♦ It is round in shape of 1 cm diameter or equivalent to 25 paise coin its thickness should contain 10 layers of red blood cells.
- ♦ 1-12 WBC should be visible in one oil immersion field microscope.

#### 5.3.1.6 Labelling of blood smear

- ♦ Put serial number, date and code number of the worker with a lead pencil on thin smear.

### 5.3.2 *High risk cases.*

High-risk cases are infants, children and pregnant women who should be covered for blood smear examination during any illness associated with fever.

The blood smears thus prepared should be handed over to MPWs (F&M) and MLVs on weekly basis.

### 5.3.3 *Treatment of suspected malaria cases.*

#### 5.3.3.1 Administration of antimalarials.

##### Precautions

- ♦ Drug should not be administered **on empty stomach** it should be taken after meals.
- ♦ Drinking water before taking drug is not considered as substitute to meals.
- ♦ Presumptive treatment should be given as a single dose.
- ♦ It should be ensured that the patient in the presence of malaria worker swallows the drug.



- ♦ The presumptive treatment given to all fever cases or cases with history of fever during the past 15 days presuming that the fever could be due to malaria.
- ♦ If any fever case shows side effects after treatment with the antimalarials, the case should immediately be referred to medical officers at primary health center for treatment.

### 5.3.3.2 Treatment of fever cases

#### Presumptive treatment

A single dose comprising of 600 mg. Chloroquine phosphate (4 Aminoquinoline) is administered in the case of adults.

#### Age wise dosage schedule

Age in years	Tablets Chloroquine phosphate(150mg base) (mg base)	(No. of tablet)
<1	75	1/2
1-4	150	1
5-8	300	2
9-14	450	3
>15	600	4

**Note :** In case the fever dose not subside even after 48 hours of administration of presumptive treatment the case should be **referred to the medical officer of primary health center** for further investigations.

### 5.3.3.3 Radical treatment

MO-PHC will train you about the dose of appropriate antimalarials as per NMEP revised drug policy – 1995 and precautions to be taken in this regard.

## **Choloquine toxicity**

For any adverse reaction like nausea, vomiting, headache and irritability the patient should be referred to the doctor immediately.

### **Precaution**

**DRUG SHOULD NOT BE ADMINISTERED ON EMPTY STOMACH BUT SHOULD BE TAKEN AFTER MEALS**

## **5.4 CONTROL OF MALARIA**

### **5.4.1 Spray Operation**

You contact the village guide/community leader and inform him the date of the spray. He should be requested to motivate the community to accept and keep their houses ready for spray.

Explain the community the benefit of spray

You inform each household regarding the date of spray and keep their houses ready for spray

The housewives should complete their routine work e.g. cooking washing etc and keep things covered before spray.

The information regarding spray should **be given 15 days prior to the date** of spray

**Spray all places like walls, ceilings, crevices empty grain storage bins, behind calendars, wall hangings, mirrors, almirahs, under cots and furniture.**

**Thatched roofs should be sprayed**

- **Cattle sheds are not to be sprayed**
- **All food articles are to be removed or covered properly before spray**



## **Prevention of malaria**

***Malaria is transmitted by mosquitoes. So try to control mosquito breeding:***

- Close water container with tight fitting lids.
- Empty water from all utensils, tins, cans, pots etc. every week.
- Drain small water collection in coolers, barrels near hand pumps, tanks, wells.
- Fill up and level depression in kitchen gardens, court yards, roofs, open spaces in village roads, ditches along the roads and canals.
- Release mosquito eating fish in ponds.

### ***5.4.2 Avoid mosquito bites:***

- Use mosquito nets at night.
- Use mosquito repellants. eg. Natural repellants like Neem leaves, preferably no commercial chemicals
- Spray operation house to house.

### ***5.4.3 Malarial Prophylaxes.***

5.4.3 (i) Chemoprophylaxis:  
Chloroquin sensitive area:

Dose 10 mgm / kg body weight as loading dose and thereafter 05 mgm / kg body weight weekly once not beyond three years.

(ii) Chloroquin resistant area:

Chloroquin 05 mgm / kg body weight weekly once ( 300 mgm an adult dose) + Proguanil 1.5 mgm / kg body weight daily (100 mgm adult dose)

## **Exercise**

- Q.1. When will you suspect fever as malaria?
- Q.2. Write the symptoms of malaria.
- Q.3. How will you collect blood for thin and thick smear?
- Q.4. How will you treat a case of suspected malaria?



# Adolescent Health

for

## *Health Assistant (Male)*





# ***ADOLESCENT HEALTH***

## **LEARNING OBJECTIVES**

*At the end of the session you should be able to:*

- ◆ Describe the physical and physiological changes during adolescence.
- ◆ Explain the psychological and behavioural changes during adolescence.
- ◆ Discuss the importance of nutrition during the period of adolescence.
- ◆ Describe the importance of personal hygiene.
- ◆ Discuss major reproductive health problems among adolescents.
- ◆ Explain your role as a health worker in educating the parents, teachers, and community including adolescents.

## **CONTENTS**

1. Introduction
2. Physical and Physiological changes during adolescence.
3. Psychological and behavioural changes
4. Nutrition and health needs in adolescence
5. Personal hygiene
6. Health problems in adolescence.
7. Crucial role of family and community in adolescent health
8. Key points.



## 1. Introduction

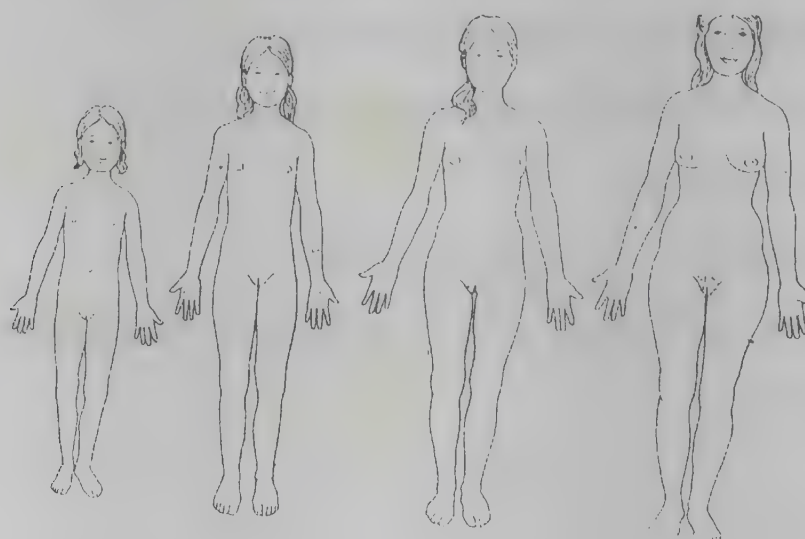
Adolescence is a period of transition from childhood to adulthood. It is the period of life between age of 10-19 years.

This period is very crucial, since these are the formative years in the life of an individual when major physical, psychological and behavioural changes take place. This is also an impressionable period of life. This is also the period of preparation for undertaking greater responsibilities including healthy responsible parenthood. Future of a society depends on adolescents and they form a great human resource for the society.

Health problems of adolescents are very different from those of younger children and older adults. Due to lack of accurate information, adolescents are prone to various behavioural and reproductive health problems. The period of transition from childhood to adulthood is hazardous for the adolescent health because they develop behavioural problems in absence of proper guidance and counselling. As a health worker, you can play very important role in preventing these problems.

## 2. Physical and physiological changes during adolescence

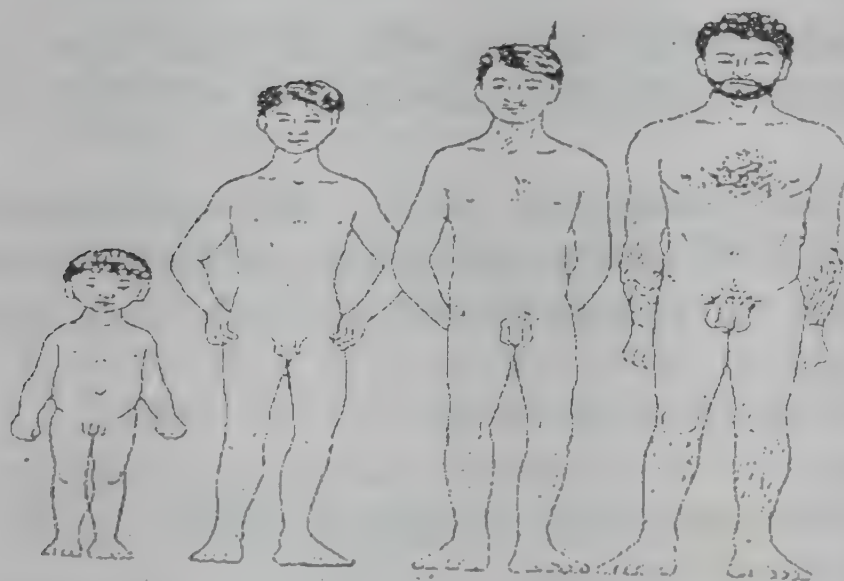
**2.1 Puberty in girls:** In girls physical changes may begin at around 10 years and may reach their maximum growth by around 14 years.



## **2.2 Menarche and Menstrual cycle**

Menarche is the onset of first menstruation which occurs in a young girl at around 12 years. This is often recognized as the onset of maturity in girls. There are variations in the age at which menarche occurs. Good nutritional status will lower the age at menarche i.e. girl will attain menarche earlier, while in malnourished girls menarche is delayed. If menstruation has not started by 16 years you should counsel the girl's parents to consult the medical officer at a health facility i.e. PHC/CHC.

**2.3 Puberty in boys:** Puberty in boys usually appears later than in girls. It may begin with change in voice, growth of hair on chin, under arms, face, chest and pubic region.



Development/enlargement of external genitals also takes place and sperm production starts. Occasionally penile erection and involuntary ejaculation also occur. The adolescent boys should know that all these changes are normal and natural

and there is no need to be ashamed of them or frightened.

## **3. Psychological and behavioural changes**

During this transition phase from childhood to adulthood due to rapid physical and sexual changes in the body, the adolescent develops anxiety and apprehension. Adolescence is a time for exploration adventure and discovery of one's own body and one's capability and potential. Some times this can lead to confusion and to experimentation with harmful substances like drugs, alcohol etc. and risky behaviour like risky driving.

Sometimes expression of sexual urge by adolescents may lead to anger among adults while among adolescents this may lead to feeling of fear, guilt and shame. Often adolescents hesitate to make communication about sexual development and other related matters with elders.

In case they are not given appropriate information and education on these normal physical, sexual and psychological changes they are prone to health risk behaviour such as sex experiments and drug abuse leading to teenage pregnancy, contracting RTI/ STI, HIV/AIDS, injuries, accidents, violence, rape, homicides, suicides etc.

#### **4. Nutrition and health needs in adolescence**

The nutritional requirement of adolescents is more due to rapid growth spurt and increase in physical activity.

You have to ensure that during this period, the adolescents are encouraged to develop healthy eating habits and life style. Good nutrition is equally important for proper growth of both male and female adolescents.

Adolescents need more of all nutrients particularly calcium, iodine and iron. The need for more iron in adolescents is due to growth spurt and the onset of menstruation. Inadequate iron stored during adolescence before conception is a major cause of iron deficiency anaemia during pregnancy, which aggravates the risks during pregnancy. In endemic areas incidence of iodine deficiency disorders is high resulting in retardation of growth, mental retardation and psychomotor development. They should take calcium rich food like milk and milk products, consume iodized salt and iron-rich food such as green leafy vegetables, whole pulses, jaggery, meat, poultry, fish etc.



Stunted and under-nourished girls are more likely to have complications during pregnancy and give birth to low birth-weight babies.

You should educate the community and family members about the importance of healthy eating habits and nutritious foods.

## **5. Personal hygiene**

It is the one of the basic components of the measures for protection of health. Adolescents should take care of personal hygiene such as:

- Clean hands thoroughly before and after taking food and after going to toilet.
- Clean teeth and tongue twice daily once in the morning after leaving bed and 2<sup>nd</sup> time before going to bed at night.
- Must take bath daily.
- Boys should give attention to clean “Smegma” i.e. (a thick secretion collected under the fore-skin of the penis) during bathing and after urination.
- Boys and girls should keep the groin clean and dry otherwise fungal infection, leading to itching etc. will develop.

## **6. Health problems in adolescence**

Some health problems among adolescents are consequence of certain child hood infections like repeated diarrhoeal and respiratory infections, polio-myelitis etc. or other factors affecting health status like malnutrition etc.

### ***6.1 Under-nutrition***

Under-nutrition among adolescent girls is major public health problem in India. Under-nutrition during childhood and adolescence leads to impaired growth, anaemia, iodine deficiency etc.

Some other problems originating during adolescence may have life long consequences like use of tobacco, alcohol, drugs and harmful substance, etc.

### ***6.2 Unprotected sex and unwanted/unplanned pregnancy***

Since adolescent sexuality remains taboo in many societies, there is widespread ignorance among adolescents about risks associated with unprotected sexual activity. Unprotected sex may lead to unwanted/unplanned pregnancy which in turn may lead to increased demand for induced abortion. Pregnancy among unmarried adolescent girls may lead them to seek abortion services from untrained practitioners and quacks and become victims of the consequent complications. Termination of unwanted pregnancy through induced abortion among adolescent girls cause greater risk to life than in adult women. Even if pregnancy continues, tendency to hide the same and to avoid proper antenatal care among adolescents may lead to serious complications of pregnancy and child birth.

### ***6.3 Risk of pregnancy in adolescence***

Health of adolescent girls is at high risk if they are married at very young age which leads to consequent early child bearing. The chance of anaemia, retarded foetal growth, premature birth and complications during labour are significantly higher for adolescent mothers and may even lead to death.

### ***6.4 Unprotected sex and sexually transmitted diseases.***

A major consequence of unprotected sex among adolescents is the change of infection from STDs which include syphilis, gonorrhea and HIV/AIDS. Young adolescents of both sexes who engage in unprotected sexual activities are highly vulnerable to STDs.



Acquiring STDs during adolescence often results in serious consequences in future like infertility, pelvic inflammatory disease, ectopic (tubal) pregnancy etc.

### ***How to prevent STDs?***

Use of condom not only provides protection against unwanted pregnancies but also against STD and HIV/AIDS. Counselling and education may be provided to the adolescents regarding need for practice of safe sex not only to avoid pregnancy but also for protection against STDs including HIV/AIDS.

Remember that adolescents have a right to complete, correct and detailed knowledge and information relating to their development; physical and psychological changes that take place during adolescence; sexuality in human beings and its implications on their health as well as means to protect themselves from reproductive health related problems.

## **7. Crucial role of family and community in adolescent health**

Family has a crucial role in shaping the adolescents behaviour. Parents and adults in the family must ensure a safe and secure and supportive environment for the adolescents during their formative years of growth and development. Family members need to be informed and educated in this regard. A positive and encouraging attitude among parents and family members to interact with adolescents and to give clarifications and correct information on their doubts will facilitate better relationship of trust and confidence.

### ***7.1 Your role to educate the community to help adolescents***

Adolescents confront a number of problems because of the lack of authentic knowledge regarding their process of growing up, particularly, the issues relating to reproductive health.

They need accurate information and do not often know from where to obtain this. Therefore you are expected to educate the



community members as well as adolescents about the normal physiological changes with special reference to nutrition and health needs of adolescents. You should educate the adolescents about healthy life style and behaviours among them.

You should take interest in teaching adolescence boy in groups i.e. in clubs, schools etc about their growth, development, nutritional requirement and other needs if any.

## **8. Key points**

1. Adolescents need extra food as they are growing very fast.
2. Adolescents are more likely to become anaemic due to rapid growth in muscle mass (and menstruation in girls) Give them more iron rich foods like whole pulses, green vegetables, jaggery, meat, poultry, fish etc. and treat with IFA tablet, if they are anaemic
3. Adolescents are under psychological stress very often, as they are becoming more independent and assertive as part of their growing up. Hence they should be dealt in a more sympathetic and understanding manner by family members, teachers and other adults in the community.
4. Adolescents are undergoing sexual development and they are curious to know about it. They should be encouraged to ask and know about this from parents, health workers and others who can give them correct information. They should be told about the risk of unprotected sexual behavior i.e. disease like STDs and AIDS.
5. Adolescents may not have adequate information about consequences of experimenting with unprotected sex, use of dangerous substances like drugs and alcohol, risky driving, smoking etc.
6. Adolescents have the right to information and knowledge about their development healthy behaviour sensitive sexual issues their own health needs etc.

7. Unprotected sexual relations increases the risk of unwanted pregnancy, induced abortion and STDs.
8. STDs are major cause of reproductive health complications and their sequel including infertility.
9. All efforts at counselling adolescents should advocate that premature, unprotected sexual relation and pregnancy in adolescence be avoided.

### **Self assessment questions**

1. What do you mean by adolescence?
2. The onset of adolescence, (Tick one of them)
  - (a) Starts earlier in boys
  - (b) Starts earlier in girls
  - (c) Starts at the same age for both boy and girls
3. The health problem during adolescence is due to; (Tick one of them)
  - (a) The health problem starting at childhood.
  - (b) Due to behavioral disorders during adolescence.
  - (c) Due to sexual behaviour during adolescence.
  - (d) All of the above.
4. The physical sign of adolescence in boys is (Tick one of them)
  - (a) Development of pubic hair
  - (b) Penile development
  - (c) Testicular enlargement
  - (d) All of the above.
5. Name some common psychological problems during adolescence  
(a) (b) (c) (d)
6. Why adolescents develop habit of tobacco, alcohol and drugs?
7. What advise will you give regarding personal hygiene to an adolescent?



















